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ABSTRACT

Developed as part of the Family, Infant, and Toddler Project, and intended as a guide for parent groups, the document focuses on such topics as instruction, child development, and family concerns related to children with handicaps. Individual topic guides provide information on ways to begin the parent group meeting, information to consider, questions to continue the discussion, and a conclusion. Many topics include information on objectives, preparation and material needs for that session. The following four topic areas are addressed (sample subtopics in parentheses): child development and child rearing of children with special needs (motor development, body positioning aids to make at home, cognitive development, and speech and language development); teaching issues (reinforcement, discipline, and play); family issues (parent needs, initial reactions, siblings); and special issues (children's vision and hearing, community resources, and educational rights for children with handicaps). (CL)

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Parent Group Guide

Topics for Families of Young Children with Handicaps

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Preface

During the 3-year demonstration phase of the Family, Infant, and Toddler (FIT) Project, one parent/infant teacher was responsible at each site for parent group. What would the topic be? Where could we find information? Did we need handouts, audiovisuals, other materials? This guide includes approaches and information we found to be useful with parents and was compiled in hopes of helping other parent group leaders.

We gratefully acknowledge all of the parents and extended family members who participated in the FIT Project parent groups. By letting us come to know you, your joys, triumphs, disappointments, uncertainties, and sorrows, you made our lives fuller. We will always remember each one of you.

We appreciate the guidance of the FIT Project director, Dr. Harris Gabel in helping us develop group leadership skills. His workshop and weekly sessions analyzing parent group discussion were invaluable.

We extend special thanks to Jan Rosemergy, coordinator of the Kennedy Center Information Services, for her advice and editing assistance.

We owe a huge debt of gratitude to our secretary, Carolyn Liu, for her patience in typing, deciphering our handwriting, and retyping and retyping until we finally had a finished manuscript.

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Introduction

Parent groups and extended family groups were key elements of the Family, Infant, and Toddler (FIT) Project. This 3-year demonstration Project was developed by the John F. Kennedy Center for Research on Education and Human Development and was funded by the Handicapped Children's Early Education Program. FIT staff members developed and demonstrated a model for serving preschool children with handicaps and their families. Families in rural areas brought their infants and toddlers to a central location, usually a church, for 3 hours, 1 day per week. Family/infant teachers taught parents or other family members activities appropriate for each child. Families used the prescribed activities at home with their children.

The 3-hour schedule of the Family, Infant, and Toddler clinics provided time for informal greetings and exchange of personal news, time for children to be together with their parents in a group, individual family training sessions, and a 1-hour parent group. Once every two or three months clinics were held in the evenings so that extended family members and parents employed outside of the home could attend. The FIT Project model is described in detail in The Family, Infant, and Toddler (FIT) Guide. A Model for Rural Family-Implemented Educational Programs (Carr, 1982).

The two main purposes of the FIT parent groups were (a) to foster peer support, and (b) to provide parents with basic information about child development and child rearing.

Families often reported feeling isolated from others because of their children's handicaps. Sometimes other people were uncomfortable with the handicap or insensitive to the difficulties the family was experiencing. In the FIT parent group parents found persons who were accepting and understanding. Others in the group had experienced many of the same problems and emotional reactions. However, it often required several weeks of meeting together to develop a caring relationship and mutual support. Leaders attempted to establish an open, accepting atmosphere in which parents received information and were provided space and time to solve problems if they needed and wanted to find solutions. Many parents were coping well with the difficulties of having children with disabilities and were eager to learn more about the disabilities and ways to teach their children.

The infant/family teachers responsible for parent groups selected a topic to be discussed each week. Parents often suggested areas of interest, and topics sometimes were chosen as a result of questions raised during the previous week's discussion. The leader gathered resources and materials for information-sharing subjects. At times the group

members' questions and comments took the discussion away from the selected topic, and the leader had to decide if the topic needed to be changed. However, once the subject was determined, the leader established parameters for the discussion and generally kept attention focused on the chosen area.

Sensitivity to the feelings of individuals was an important quality for leaders to have. Acceptance and understanding was communicated when leaders listened reflectively, restating the problems or emotions that parents had expressed. Whenever possible, leaders sought to create support among group members. One way of facilitating support was to ask, "Has anyone else had the same problem?" "...or felt the same way?" in response to one person's shared experience. Group leaders were teachers, not therapists, but they empathized with parents, shared their experience of working with children with handicaps, and were concerned for and cared about parents and children in the Project.

Since several of the infant/family teachers led groups at different sites, they were able to share ideas and materials, and provide support for one another. In addition, the Project director, a clinic psychologist, provided a workshop in family counseling techniques and met with teachers for several months to discuss ways to handle situations as they arose in the groups.

Parent Group Guide: Topics for Families of Young Children with Handicaps was developed to suggest topics to provide information of interest to parents and other persons caring for young children with handicaps. It also includes some ideas for structuring the group time and planning discussion. It does not include information about group leadership or group counseling skills. References at the end of the "Introduction" will provide help in the area of group leadership skills.

The material contained in this guide is intended to be adapted for individual groups. The modules may be presented in the order which seems to be most useful. However, "Next Steps" suggests modules which cover similar topics and may be helpful in sequence. The section "Ways to Begin" provides a common starting point for discussion based on group members' experiences. The section "Information to Consider" is not meant to be delivered as a lecture. It is information that may be useful for leaders to have in preparing for sessions. The information should be personalized. The key sections in each module are "Ways to Begin" and "Questions to Continue the Discussion" since these ideas will help to stimulate interaction between parents and extended family members.

Most of the modules in this guide were topics of FIT parent discussion groups. In most cases, authors have led sessions on the subject about which they have written. The guide has been produced in loose leaf form to allow easy removal of handouts for duplication and to make possible the addition of other materials that individuals may find helpful.

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CHILD DEVELOPMENT AND CHILD REARING OF CHILDREN WITH SPECIAL NEEDS

MOTOR DEVELOPMENT

Jacqueline Bly Sweat

Motor development is the process by which growing children gain control over their movements. Newborn babies' motor skills are primarily limited to reflexive movements, which are automatic responses to specific stimuli. As infants grow, these reflexes are integrated into more mature movement patterns which children are able to use at will. By the time children are about 5 years old, they have learned to hold their heads up, sit up, crawl, stand up, walk, and run. They have also gained control of the small muscles of their hands, feet, and face, which allows them to manipulate objects, to feed themselves, and to perform myriad fine motor tasks. These motor skills develop as the children use their rapidly maturing bodies and nervous systems to move in and explore their environments.

While most children develop motor skills at approximately the same rate and sequence, some children demonstrate atypical motor development due to a variety of physical or environmental problems. Early intervention can help such children develop as normal motor functioning as possible.

Objectives

1. Parents will be provided with information about normal motor development.

2. Parents will learn the causes and effects of atypical motor development in young children.

3. Discuss the need for early intervention and different types of intervention. Encourage parents to discuss problems or progress that they have seen in their children's motor development and types of interventions being used with their children. (15 minutes)

4. Conclusions and next steps. (5 minutes)

Ways to Begin

1. Ask what part of their bodies children gain control of first (head). Explain that motor development proceeds from head to foot (cephalo-caudal).

2. Ask in what order children gain control of their arms, hands, and fingers (arms, whole hand, then fingers, finally achieving a pincer grasp).

3. Ask parents to state their immediate goals for their children's motor development.

Information to Consider

Motor development is the process by which maturing children gradually gain physical control of their bodies, developing the ability to move actively and purposefully within and to interact with their environments. Motor development includes the development of movements that involve large muscle groups (for example, sitting and walking) as well as movements that involve small muscle groups (for example, grasping, moving toes, and fingers). Motor development begins before birth and is not complete until children are 5 or 6 years of age (Connor, 1978).

Motor development influences and is influenced by other areas of development. For example, children's cognitive skills are enhanced by their ability to move in and explore their environments at the same time that their motivation for exploring and moving are reciprocally influenced by their emerging cognitive abilities. Language development involves the development of the mouth, tongue, and throat movements needed for vocalizing, as well as the understanding of concepts which are, at least in part, acquired through physical exploration and manipulation. The development of self-care skills is also greatly influenced by children's motor development - for example, children require stability, balance, and fairly precise movements to dress, feed, and bathe themselves. Motor and sensory developmental processes are so closely intertwined that early child development is referred to as sensorimotor development (Connor, 1978).

All children develop motor skills in much the same sequence. Children build new movement upon the foundations of previously acquired motor skills. However, the ages at which skills and variations on skills are developed depend on children's individual physical characteristics in combination with individual aspects of their environments (such as the presence of other children as models, parental guidance, and opportunities to practice developing skills) (Ford, 1975; Connor, 1978).

Normal Motor Development

Newborn infants have very little voluntary control over their movements. Most of their movements are reflexive--that is, automatic responses to stimulation they receive through their senses. Some reflexes that are present at birth are: (a) the rooting reflex--brushing babies cheeks causes them to turn their heads toward the side that was touched; (b) the grasp reflex--babies close their fists when their hand is touched; (c) moro reflex--movement of babies' heads backwards or shaking the surface they are lying on causes their arms and legs to move up and out. (The rag doll might be used to demonstrate.) These and other primitive reflexes help children to survive and provide automatic move-

ments which they can practice. Over the first months of life, as babies' nervous systems mature, these reflexes gradually fade and babies are able to modify and develop more voluntary control of their movements (Coley, 1978).

As babies develop, they acquire the ability to "right" themselves--that is maintain their heads at midline to their bodies and restore the alignment of their heads to trunk and trunk to limbs. Equilibrium reactions also develop in which chidlren are able to maintain and restore their balance. (Demonstrate with rag doll.)

The development of motor milestones follows a sequence. The general direction of development is head to foot (cephalo-caudal) and near to remote in relation to the body's midline (proximal-distal). Head to foot development can be seen in that children's first voluntary movement is lifting their heads. They develop head control and sitting balance before they are able to stand or walk. Proximal-distal development is apparent in that maturation occurs at the center of the body and proceeds to the extremities. Children develop control of their trunk and shoulders before they have full control of their arms, and they gain control of their arms before they use their fingers well. For example, they hit at objects before they can voluntarily grasp and manipulate them. (Demonstrate cephalo-caudal and proximal-distal with doll.)

Knowledge of directionality of motor development is very important in determining goals in working with children who have motor impairments. For example, children who have not yet developed good trunk control and shoulder stability will have difficulty using their hands well; therefore, a goal in working with them would be to further develop trunk control, while providing artificial support with adaptive devices for fine motor tasks.

Atypical Motor Development

While most children follow the same general pattern and rate of motor development, some children demonstrate very different patterns of development. Such children develop atypical movememt patterns and muscle tone and achieve major motor milestones at a much slower rate than other children do.

There are many reasons for atypical motor development including environmental milestones, delayed physical maturation and development, sensory or perceptual deficits, orthopedic handicaps, and brain damage affecting motor areas of the brain (Bunker, 1978). Environmental limitations restrict the types of motor experiences available to children. For example, a child who is kept in a crib most of the time may develop motor skills more slowly than a child who is placed in a variety of different positions and settings. Overprotective parents may fail to provide the children with opportunities to develop more abilities by not allowing them to explore their surroundings. Such children often catch up in their motor development if changes occur in their environments.

Children who are blind or deaf receive inadequate or distorted stimuli from their environments and are unable to produce appropriate motor responses (Healy and Stainback, 1980). Visually impaired children are particularly affected because they are not usually stimulated to move and lack the visual feedback necessary for them to steer themselves within their environments (Bunker, 1978). Studies of visually impaired children have indicated that neuromuscular maturation and postural achievements appear within normal age ranges, while mobility and locomotion are most often delayed (Adelson and Fraiberg, 1975).

Orthopedic handicaps such as spina bifida, absence of limbs, and polio will often cause delays or absences in the development of motor skills. Children with such handicaps require intervention in the forms of physical therapy, adaptive devices, and sometimes surgery to maximize motor development.

Children who are brain-damaged either before birth or in early childhood may display atypical or delayed motor development. Cerebral palsy is an example of such brain damage. In normally developing children the higher centers of the brain gradually impose control over the lower centers, allowing children to acquire motor skills in a fairly orderly sequence. Damage to the immature brain can prevent higher brain centers from developing; therefore, movement patterns and muscle tone will develop atypically (Connor, 1978). Brain-damaged babies may display reflexive behaviors that are exaggerated, and they may be unable to break out of these reflexes on their own. Such reflexes also tend to persist longer in children with brain-damage than in other children and prevent the development of advanced motor skills. For example, the asymetrical tonic neck reflex can be seen in most children at about 1 month of age, but may persist much longer in children with brain damage. If a child's head is turned on one side, the arm and leg on that side of the body extend while the opposite arm and leg flex. (Demonstrate with the rag doll.) Babies with normally developing motor

Asymetrical Tonic Neck Reflex

patterns can move out of this reflex on their own, and the reflex usually is no longer apparent after about 6 months of age. However, in brain-damaged children, this reflex and other reflexes are sometimes obligatory (children cannot move out of them on their own) and often persist well beyond 6 months of age. Children with a persistent asymetrical tonic neck reflex will have difficultiy bringing their hands or objects to their mouths or bringing both hands to their midlines. Many other reflexes can persist in brain-damaged children and can greatly affect the development of more advanced motor skills (Healy & Stainbach, 1980). Because brain-damaged

children do not know other movement patterns, they use those movements they have. Continuous use of atypical patterns can further strengthen those patterns, causing additional problems such as contractures (muscles becoming tight and fixed in a certain position) and deformities, and limit the development of normal motor skills (Connor, 1978).

Interventions

Very early therapy, proper positioning and handling, and medical intervention can minimize the effects of atypical motor development in many children. The services of a pediatric physical therapist on a regular basis are essential. Physical therapists evaluate children's present motor functioning and prescribe appropriate interventions. Interventions for children who are motorically delayed but otherwise developing normally might consist primarily of developmental play activities to foster more advanced motor functioning. Interventions for children who are neurologically damaged would probably include: 1) proper handling techniques (for example, aligning the body properly, stabilizing the body, changing positions correctly, normalizing positioning and carrying, positioning to facilitate learning, and arranging the environment for maximum interaction), 2) normalization of muscle tone, 3) inhibition of abnormal reflex patterns, 4) development of more advanced motor skills (Healy & Stainback, 1980).

While a physical therapist may work directly with a child on a regular basis, parents and teachers need to be able to supplement the therapist's interventions. It is especially important that parents and teachers provide proper handling and positioning while they work to further develop children's motor skills. Formal physical therapy performed with children on a monthly, weekly, or daily basis can quickly be negated if other caregivers are not following through at home and in school. The physical therapist should work with a child's caregivers to help them carry out treatment plans. Physical therapists also should provide clear written instructions to which caregivers can refer between physical therapy treatments.

Although the physical therapist is usually the primary person responsible for children's motor programming, a number of other professionals often will be working with children and their parents in developing a comprehensive motor development program. These might include doctors such as pediatricians or orthopedists, speech therapists who prescribe feeding and positioning techniques which will facilitate prespeech behaviors and vocalizations (Langley, 1979), and educators who help in facilitating the cognitive abilities needed for motor development. Care should be taken that all these professionals work closely with each other and with children and their families to insure that a well-integrated motor development program is carried out.

Questions to Continue Discussion

1. Ask parents for examples of activities, events, and circumstances that they think have contributed most to their children's motor development.

2. Ask how parents have adapted their children's environment to help them develop motor skills.

3. Ask parents to demonstrate with the rag doll techniques that physical therpists have taught them.

Next Steps

1. This module provided a brief overview of motor development. If several children of parents in the group have specific motor handicaps, the group leader might want to use this module as an introduction for a comprehensive unit on motor handicaps. Other topics of interest to parents might include (a) cerebral palsy (b) positioning and handling handicapped children (c) correct positioning for the mother (d) adaptive equipment. Mothers Can Help provides summaries of these subjects.

2. Invite a physical therapist to demonstrate handling techniques to parents.

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BODY POSITIONING AIDS TO MAKE AT HOME

Maria N. Donofrio

[Note to leaders: This module serves as a model for a "make-it-take it" parent group session. The amount of information presented about positioning and handling children with disabilities is limited to allow time for parents to make the items. An introductory session about motor handicaps and the benefits of correct positioning, and/or a visit from a physical or occupational therapist are recommended. Background information provided in this module is a review of highlights of facilitative positioning principles.]

Infants and children become just as uncomfortable as adults do when they are limited to a particular position for an extended length of time. Some infants with handicaps cannot easily assume many positions. Changing their positions provides them with choices they normally cannot acquire independently. New positions allow for new perspectives and encourages motor development. Positioning equipment helps children with handicaps maintain body positions that they cannot assume by themselves. Homemade positioning aids provide this help at little cost.

Objectives

1. Parents will be introduced to (or will review) concepts of positioning.

2. Parents will learn the benefits of positioning and positioning aids.

3. Parents will learn about aids that support children in a specific position.

4. Parents will learn how to make low-cost positioning aids.

Preparations

1. Duplicate directions for construction of aids. (See handouts at the end of this module.)

2. (Optional) Contact a physical therapist or occupational therapist to present positioning aids and ways to individualize the equipment.

Materials

To Construct Corner Chair

Two square boxes (sides at least 15" high)

Sharp knives (mat- or hobby knife)

Rulers, yardstick, or measuring tape; pencils; scissors

Heavy packing tape or glue

Rug scraps or contact paper (optional)

To Construct Floor Table

Rectangular box (approx. 15" x 20" x 15")

Sharp knives

Rulers, yardstick or measuring tape; pencils; scissors

Heavy packing tape

Contact paper (optional)

To Construct Sidelyer

One piece of upholstery foam (at least 15 x 20 x 4) for each sidelyer

Knife with a long blade (electric carving knife or serrated bread knife)

Measuring tape; felt marker

Piece of fabric or pillow case for cover

Sequence

1. Choose one of the "Ways to Begin" to help parents begin to think about positioning. (5-10 minutes)

2. Provide information about positioning and the use of positioning equipment. (5-10 minutes)

3. Distribute instructions for making positioning aids and prepare for construction. (5 minutes)

4. Demonstrate each step in the construction of the corner chair, sidelyer, and table. (5-10 minutes)

5. Arrange the group so that each parent has enough space to work. Have the parents start construction. Circulate among them for assistance. Each aid will have slight modifications designed for the individual child. (30 minutes)

6. Conclude with clean-up. (5 minutes)

Ways to Begin

1. Ask parents to think about a young baby's photography session at home or in a studio. What did the different poses look like? Did the photographer use props to position the baby? Did the props change the appearance of the baby?

2. Ask parents to recall the last gathering they attended; for example, PTA, church, or a performance. Ask whether the seats were comfortable. Ask how parents felt after sitting for awhile. Ask what they usually do when they are uncomfortable.

3. Young children wiggle and squirm a lot, and adults often tell them to be still. Ask the parents if they could sit still without moving for a long time--or half of the parent group period, for 30 minutes. Ask them not to move at all for 3 minutes while the leader distributes papers and supplies. Discuss how it felt to be immobile for awhile.

4. If a physical or occupational therapist who is familiar with handicapped infants has been invited, ask her/him to present principles of positioning to parents and to help with the individualizing of the aids.

Information to Consider

Use of Homemade Aids

The positioning aids selected for this module are intended only to suggest basic concepts about positioning and positioning aids; these aids may not be appropriate for all children. A physical or occupational therapist should be consulted to determine the appropriateness of the aids for individual children, particularly for children with motor handicaps. Aids are therapeutic measures. Positioning aids that are inappropriate can hinder rather than enhance a child's development and do more harm than good.

The sidelyer is useful for children who cannot maintain a sidelying position alone and lack the trunk control to sit alone. A sidelying position enables children with an asymetrical tonic neck reflex to bring their hands together, to look at objects in their hands, and to see objects placed at their sides.

The corner chair is useful for children who have some trunk control but still need support to maintain a sitting position.

The floor table provides a surface for activities for children who cannot yet sit in child-sized chairs at small tables. The floor table may be used with the corner chair, with an infant seat, or with other special seating that is placed on the floor. It may also be used with a child seated in an adult's lap on the floor or with a child who can sit independently on the floor.

Positioning in Adults

Adults and children, whether they are awake or asleep, spend much of their time moving and adjusting their bodies. Body adjustments are so natural that for the most part individuals are unaware of them. People move to achieve comfort, to maintain balance, to position themselves for work, to look at the world and events surrounding them. People prepare themselves for participation in an event by putting their bodies in a particular position. Imagine the confinement one would feel if it were impossible to move whenever and wherever desired. There are many naturally occurring situations that simulate the frustration of minimal or reduced movement, such as having an injured arm or leg, staying in a hospital, or being kept indoors by bad weather. Usually these conditions are temporary and persons know that they can soon return to regular patterns of movement.

Positioning in Infants

At very young ages, babies spend much of their time learning to move to different positions; for example, rolling over, lying on stomach or back. Often these movements help infants explore their environments by placing them in advantageous positions. Babies placed on their stomachs learn to lift their heads to see what is around them. Babies may begin to cry when they are stuck in one position and cannot change.

Infants and some children with motor or developmental handicaps sometimes do not have the same freedom to move as other childrne have. Their muscles and movements are inhibited or immature, and they need other people to help them change positions. Without these people who care for them, they often would spend much of their time in a single position. Positioning impaired individuals becomes as important a goal as providing enriching learning experiences. With correct positioning in sitting or in lying on stomach, side, or back, children's bodies are ready for the tasks at hand.

When adults position their bodies for a task, they usually adjust their posture for the best balance, support, and comfort for that situation. These same objectives need to be considered when arranging positions for children. Just as there are many positions that adults assume which are appropriate for their needs, there are many positions available to young or handicapped children.

Benefits of Positioning

There are several benefits to correct positioning. First, correct placement assures children's comfort. Second, when children are relaxed and secure, they can give their full attention to play or to a prescribed task. Finally, the correct position can help the muscles support more normal body movements by inhibiting or preventing abnormal patterns. In a correct position children are not putting improper stress on their bones or joints.

Role of Physical Therapists

Since each child's motor patterns are unique, a physical therapist can suggest and prescribe various positions necessary for a child's needs. There are body positions that facilitate learning (for example, at a table). playing, sleeping, and relaxing. There are positions or handling techniques to help parents carry, bathe, feed, and dress their children. Physical therapists make suggestions for each of these situations. They check for many features that influence the development and formation of child's bodies, including (a) muscle tone (tight/spastic or loose/hypotonic), (b) straightness of the spine, (c) whether the head and hands need to be in the center of the body (midline) for performing a task, and (d) ability to maintain a position independently.

Positioning Aids

Children may not be able to maintain some of the recommended therapeutic positions on their own. A very young baby placed in a high-chair the first time often needs pillows or towels for support. A young child needs support to maintain new positions such as sitting and standing: at first someone holds a child in these new positions. Positioning aids are available to help support children in different positions without being held. Many companies manufacture equipment, (for example, special chairs, feeding tables, bath aids) to help parents position their children. These aids are prescribed by therapists and may be constructed for individual children. Often therapists suggest modifications and additions for furniture and equipment that the family already owns. Sometimes positioning aids can be constructed at home following the specific suggestions of physical therapists. Many of the chairs and sidelyers follow simple plans that can be assembled with wood or even cardboard. Some resource guides for parents such as Mother's Can Help (1976) and Handling the Young Cerebral Palsied Child At Home (1977) publish directions for different positioning equipment.

The therapist can suggest the correct time and place to use positioning aids. With these aids children can maintain different postures. Not only will these different movements and perspectives add variety to their lives, but they will also facilitate their physical growth and overall development.

Procedures

A "make-it-take-it" workshop sometimes seems to be chaotic. Several precautions ensure a smoother group session: (a) gather all materials ahead of time; (b) place each person's materials, tools, and directions in work sections prior to the group meeting; (c) practice "direction giving" techniques before the session; (d) allow adequate time for each step of the procedures.

The remainder of the parent group session consists of the construction of low-cost positioning aids. Different equipment can be substituted for the corner chairs, floor tables, or sidelyers, provided time and material allowances are adjusted. Changes in the following procedures will vary with individual groups. (See "Reference" section for other aids.)

1. Distribute copies of directions and materials.

2. Divide the group according to their interest in tables, chairs, and sidelyers. Since the directions for each are relatively short, review them with the total group.

3. Let group members proceed on their individual projects; assist parent individually with measurements or construction.

4. Have parents "fit" the new "equipment" to their children. Make further adjustments that are suited for their child; for example, lower the table or chair back or enlarge the cut-out space in the table.

5. Parents can pad chairs with rug scraps; cover the cardboard pieces with plastic coverings, such as contact paper or cover the sidelyer with fabric.

6. If time permits, parents can make another project (for example, a floor table to go with the chair).

7. Clean-up time.

Conclusion

Summarize the basic information about body positioning. Review the benefits of correct positioning. Remind parents that their children should be supervised with in the aids and should never be left unattended.

Next Steps

1. Other "make-it-take-it" parent group topics include:

   - Making inexpensive feeding aids
   - Making play clay
   - Making nutritious snacks that contain little sugar
   - Making picture books
   - Making learning toys

FLOOR TABLE DIRECTIONS

1. Step one — Gather materials

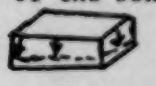
1 Sharp kitchen knife
2 Rectangular cardboard boxes (identical boxes) approximate dimensions (24" length x 15" width x 10" depth)
1 Yard stick
Marker
Scissors

2. Step two — Prepare the boxes for proper height

Cut off the top flaps of the boxes
Decide on the appropriate height of the table

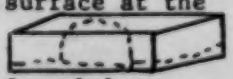
a) Place your child in a sitting position (for example, on the floor or in a low adaptive chair).
b) Bend his or her elbow parallel to the floor.
c) Measure the distance between the sitting surface (floor or seat of chair) and the bent elbow.

Turn the boxes upside down
Measuring down from the solid surface, draw a line around the sides of the boxes at the child's table height.



3. Step three — Prepare the legholes

Draw a semi-circle on the table surface at the edge of the boxes
(Diameter 12 inches)
Extend the lines down one side of each box.

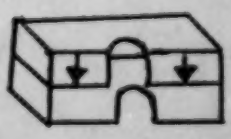


4. Step four — Cutting the boxes

Using a sawing motion, cut along the cutting lines.
You may have to use a scissors to finish the edges.

5. Step five — Assembly

Fit one table box inside the other one.
Glue or tape the boxes together.



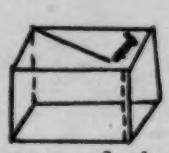
6. Step six **Finishing Touches**

Cover the box table with contact paper

CORNER CHAIR DIRECTIONS

1. Step one — Gather materials

   1 Sharp kitchen knife
   1 Square heavy duty cardboard box (liquor boxes) dimensions (15" x 15" x 15"; approximate)
   1 Yardstick
   Marker
   Scissors



2. Step two — Prepare box

   Cut off the top flaps of the box
   Turn the box upside down
   Draw a diagonal line across the bottom of the box with a marker

   Extend the line down the two sides of the box (dotted lines)

3. Step three — Cut the box

   Using a sawing motion, cut along the line. You may have to use scissors to finish the cut edges.

4. Step four — Assembly

   Take the two triangular sections and nest one inside the other.
   Glue or tape the two corners together.

5. Step five — Finishing Touches

   Cover the chair with contact paper or rug scraps

SIDELYER DIRECTIONS

1. Step one — Gather materials

1 Electric knife or serrated knife
1 Piece of 4 to 5 inch thick foam
(at least a 24" x 24" piece)
1 Felt tip marker
Pillow case or fabric (optional)
1 measuring tape
Pillow case or material

2. Step two — Measure child

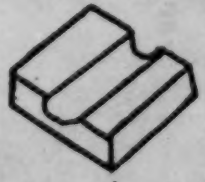
Place child in a sidelying position
Measure your child from just under the arm to mid-thigh. This measurement is the length of your sidelyer.
Measure the approximate width of your child's body. This measurement is the width of the channel of the sidelyer.

3. Step three — Prepare the foam

Using the electric or serrated knife cut the foam to the proper dimensions--length: measurement from underarm to mid-thigh by width: 3 times the measured width of the child.
Using the felt marker draw a channel down the center of the foam the width of your child's body. At either end of the channel draw a semi-circle being sure to leave 1-inch clearance at the bottom.

4. Step four — Cutting the sidelyer

Using the electric or serrated knife cut out the semi-cylindrical piece of foam. Your child should fit in the opening when lying on his/her side.



RESOURCES FOR COMMERCIAL ADAPTIVE EQUIPMENT

The addresses of supply houses for special adaptive equipment and materials for use with individuals who are handicapped are listed below.

Achievement Products, Inc.
Box 547
Mineola, New York 11501

Amigo Sales, Inc., Dept. EP-67
6693 Dixie Highway
Bridgeport, Mich. 48722

Bobby-Mac
Dept. 47
P.O. Box 209
Scarsdale, New York 10583

Community Playthings
Rifton
New York 12471

Everest & Jennings
1803 Pontuis Avenue
Los Angeles, Calif. 90025

Fred Sammons, Inc.
Box 32
Brookfield, Ill. 60513

Genoe
2220 Norwood Avenue
Boulder, Col. 80302

Invacare Corporation
1200 Taylor Street
Elyria, Ohio 44035

J. A. Preston Corporation
60 Page Road
Clifton, N.J. 07012

Kaye Products, Inc.
(Adaptive equipment for children)
202 South Elm Street
Durham, N.C 27701

MED (Medical Equipment Dist.)
1215 S. Harlen Avenue
Forest Park, Ill. 60130

Mulholland Growth Guidance Equipment
1563 Los Angeles Avenue
Ventura, Calif. 93003

Special Education Materials, Inc.
484 South Broadway
Yonkers, New York 10705

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Finnie, N. Handling the young cerebral palsied child at home, New York: Dutton-Sunrise, Inc. 1975.

Haring, N. G. Guidelines to positioning and adaptive equipment. The experimental education training program: An inservice program for personnel serving the severely handicapped. Seattle, Washington, Child Development & Mental Retardation Center, Vol. II.

Kohl, F., & Westengerger, J. Adaptive equipment for students with severe physical handicaps: Goals, objectives, and construction plans for use in the classroom. Paper presented at the Illinois Office of Education Annual Statewide Institute for Educators of the Severely/ Profoundly Handicapped, Chicago, February 1979.

Wilbur, S. Foam rubber sidelying support for children with cerebral palsy. Physical Therapy, 1975, 55, 1345. (Photograph included)

For More Information

For Leaders

Hofman, R. B. How to build special furniture and equipment for handicapped children. Springfield, Ill.: Charles C. Thomas, 1975.

Bergen, A. Selected equipment for pediatric rehabilitation. Valhalla, N. Y.: Blythedale Children's Hospital, 1974.

Gilleth, H. E. Systems of therapy in cerebral palsy. Springfield, Ill.: Charles C. Thomas, 1974.

For Parents

Hughes, K. & Gordon, E. A change for the better: Practical ideas for adapting home and school equipment. Nashville: Instructional Media Production Project for Severely Handicapped Students.

(NOTE: The above resource is not yet commercially available. For further information contact, LIMC Resources, Inc., 1875 Morse Road, Suite 225, Columbus, Ohio 43229.)

COGNITIVE DEVELOPMENT--HOW INFANTS LEARN TO THINK

Jacqueline Bly Sweat

Infants are competent, developing human beings who from birth learn and grow as a result of their interactions with persons and objects in their environments. Jean Piaget described infant development as moving through six stages, with each stage building upon the previous ones. A brief summary of the six stages is given on a handout at the end of this module.

Objectives

1. Parents will be provided with information about normal cognitive development during the sensorimotor period.

2. Parents will be more observant of cognitive development in their children.

Preparation

1. Make copies of the "Sensorimotor Development" handout.

2. (Optional) Gather pictures of children to illustrate aspects of the six stages of sensorimotor development.

3. (Optional) Order videotape demonstrating the sensorimotor stages in "For More Information" section.

Sequence

1. Use one of the "Ways to Begin" to help group members think about the development of cognition.

2. Briefly introduce infant cognitive development as described in Part A of "Information to Consider." (5 minutes)

3. Describe each stage of infant development as discussed in Part B of "Information to Consider." Ask questions listed for each stage of development in "Questions to Continue Discussion." Interject questions at appropriate places throughout the discussion rather than waiting until all stages have been discussed. (20-30 minutes)

4. Show pictures or videotape, pointing out examples of the various stages. (20 minutes)

Ways to Begin

1. Ask parents how early they thought that their babies could see, hear, and respond to objects, events, and people around them.

2. Distribute the handout giving an overview of sensorimotor development.

3. Ask parents to share an example of a way that their children solved a problem.

Information to Consider

Introduction

Until about the last 25 years, very young infants were considered to be totally without the ability to take in, respond, and learn from people, objects, and sensations in their environments. However, recent research on infant development has uncovered firm evidence that newborns are capable from birth of responding to and learning from their environments (Dunst, 1981). In fact, infants not only respond to their environments, but they also actively seek out and even control their interactions with caregivers. For example, very young babies have been shown to differentiate between their mother's face and voice and a stranger's. Infants gaze intently at their mothers' face for long periods but look at strangers for much shorter periods and even turn their heads away, as if to block the stranger from sight. Previously, very young babies had been thought to be unable to see well enough to focus on a human face, much less differentiate between faces.

Stages of Infant Cognitive Development

Several theories of infant cognition or thinking have been developed during the last century. One of the most influential theorists has been Jean Piaget, a Swiss psychologist who studied his own children. Piaget described infant cognition as occurring as a result of the interactions of the growing, developing infant with the environment. Babies absorb information from these interactions, build their understanding of their world, and absorb and understand progressively more complex information. Piaget divided infant cognitive development into six stages covering approximately the ages 0 to 18 months. These stages are described below:

Stage I: The Reflexive Stage (0-1 month). Infants are born with several reflexes which are automatic. They are able to grasp objects placed in their hands, suck objects placed in their mouths, respond to light, and vocalize. Infants begin using these reflexes at birth. Even before birth, babies exhibit some of these reflexes, such as sucking. These primitive reflexes are often mechanisms for survival and are automatic in response to stimulation. For example, although babies first attempt to suck anything that touches their mouths, as they experience more and more opportunities for exercising the sucking reflex, they soon learn to distinguish between sucking that provides nourishment and sucking that does not provide nourishment. If they suck on a hand, a cheek, or

the wrong part of a breast, they soon learn to stop sucking when their sucking is not followed by swallowing. They then search actively for the nipple that does provide nourishment. As this example demonstrates, a baby begins making discriminations (in the case, "nipple" from "not nipple") very early in life. Piaget describes active searching for the nipple and rejection of non-nipple at about 20 days of age in his own children.

The other reflexes are modified similarly from birth. Babies shift from passively using reflexes in response to stimuli to actively exercising these readymade actions (Hunt, 1961).

Stage II: Primary Circular Reactions (1-4 months). Babies continue to use the reflexive actions of Stage I, gradually modifying them as new and different forms of stimulation are available until they are using two or more of these actions, or schemata, together. For example, babies practice the sucking reflex, refining their ability to search out and suck what is pleasurable. During the course of their explorations they learn to stick out their tongues, lick their lips, and blow bubbles, all of which are variations of their sucking reflexes. At the same time they have been moving their arms, generally only as an activity in itself, not as an attempt to reach out and grasp anything. Their hands may accidentally touch their mouths and they may begin purposeful attempts to put their hands in their mouths. Gradually they develop a new ability.

Another example of a primary circular reactions occurs when children learn to coordinate looking with hand movements and begin actively looking at their hands. Again, this behavior begins accidentally. Babies see fingers wiggling and focus on the movement. With practice they learn to wiggle their fingers to see the interesting movement.

Stage II behavior is marked by the coordination of reflexive behavior into more complex behavior. Babies experience pleasure in this behavior centered around their own bodies, their first real toys!

Stage III: Secondary Circular Reactions (4-8 months). Children continue to exercise and expand the new abilities of the previous stage of development, with one major change. They learn to effect changes on their external environment. For example, babies might accidentally wiggle their cradle by kicking their legs or moving their arms, thus causing a mobile hanging over them to move. After doing this accidentally several times, they gradually realize that their movements are causing the interesting movement of the mobile, and they begin to wiggle in order to see the mobile move again. They have begun to learn means-ends behavior--in this example, that wiggling is the means that causes the end result of the mobile moving. Children at the developmental stage of secondary circular reactions become interested in eliciting responses from a variety of objects and persons in their environmments. They will hit or kick objects placed within their reach, will activate Busy Gyms or Busy Boxes, and will play with simple sound toys to activate the sounds. They also begin to engage in reciprocal play with adults--showing by actions, sounds, and facial expressions, that they want them to continue a game. For example, after a mother bounces a child on her knee, she might pause. The child will bounce

up and down a few times, babble, and show that he wants to play the game again. Children at this stage learn rapidly ways to get adults to repeat interesting games. This stage is important because children learn that their actions can control not only their own bodies but also their external environment.

Stage IV: Coordination of the Secondary Circular Reactions (8-12 months). During this stage, children apply actions that they have learned in the previous stage to new objects and situations. Most importantly, they begin to separate means from ends behavior, combining two or more actions that they can already perform to achieve a desired goal. For example, if a child's favorite toy is within reach but behind her pillow, she uses the previously learned action of hitting or pushing at her pillow together with the previously learned action of reaching and grasping to obtain the toy. Other examples are crawling or scooting or pivoting on her stomach to obtain an object placed out or reach and pulling a string or cloth to get a toy.

Children in Stage IV have made considerable progress over the previous stage of development. However, they continue to use behavior that in the past has worked in similar situations without being able to modify the behavior if the actions do not work in the new situation. For example, if holding a block and roughly clinking on the opening of a can resulted in getting the block to fall into the can in the past, a child is likely to continue to clink a shape on a formboard, without attempting to shift the position of the shape to fit it into the shaped opening. At this stage of development, children do not appear to understand that a new means behavior is required to attain the desired end (Dunst, 1981).

Stage V: Tertiary Circular Reactions (12-18 months). At this stage of development, children continue to combine actions to develop means-ends behavior as in Stage IV. However, in Stage V children do not rely entirely on previously used actions to obtain the result that they are seeking. Instead they begin actively experimenting to find new approaches to solve problems or to explore objects. They also begin to explore objects in new ways and become interested in the new things that they can do with familiar objects.

Piaget (Hunt, 1961) describes this process of exploration with Laurent, one of his own children. Laurent, who was 10 months old, picked up a white metal case for shaving soap, which he was seeing for the first time. He examined it, as he did most objects, by passing it from hand to hand and turning it over. Then the slippery case slid out of his hand accidentally several times. Laurent became interested in the spectacle of seeing the case fall and began letting it go, over and over again, more and more systematically. For several days he practiced his new activity. He applied the new action to other objects until he was throwing many different objects and actively experimenting with how far he could throw them and where they would land. He had learned to apply a new action to familiar objects.

Stage V is marked by children's use of trial and error problem solving. Children in Stage V are not yet able to use mental representation

to solve a problem but instead use a series of actions that they already know, modifying them until they accidentally come upon the solution. This type of behavior is seen in the child who is given a three-piece formboard. He will usually push, slide, or bang one piece and then another, paying little attention to the shape of the pieces. He will arrive at the solution to the problem accidentally through his manipulations, rather than by thinking through the problem.

Stage VI: Invention of New Means Through Mental Combinationa (18-24 months). Children in Stage VI are able to solve some problems by thinking about the solution. They do not have to go through the trial and error activities of the previous stage to arrive at a solution. For example, if a child is given a three-piece formboard, he picks up the circle, looks at it, looks at the three spaces on the board, then places the circle in the correct space. He does not have to attempt to put the circle in all the holes to find the correct solution. Instead he is able to visualize in his mind that the round shape would fit in the round hole and he moves directly to that hole.

The ability to think symbolically is necessary for meaningful language and for higher-level problem solving. For example, the ability to know that the words "want cookie" will get a child a cookie depends upon her ability to know what the word "cookie" represents if the object "cookie" is not before her, and to know that the word "want" may get her a cookie.

An example of using symbolic thought in problem solving can be seen when children put on their shoes. A very young child will try over and over to put the right shoe on the left foot or vice versa; or to put his feet in the shoe without first unbuckling it. An older child will look at the shoes, will determine mentally how to arrange them to get them on, and will proceed without further trouble. Symbolic thought, which gradually develops through children's continuing interactions with their environments, is the culmination of the sensorimotor period of development and a prerequisite for more advanced thinking skills.

Questions to Continue Discussion

Interject these questions during appropriate parts of the discussion so that parents will relate the information to their own experiences.

1. Introduction. Ask parents if they can think of some things their newborn babies did that made them know that their babies were seeing, hearing, responding, or learning from events, objects, or people around them.

2. Stage I. Ask parents if they can remember some basic reflexes that they saw in their very young infants, and how their infants gradually began to use these reflexes more purposefully, rather than just automatically.

3. Stage II. Ask parents for examples of some of the first things babies do in combining reflexes to get pleasure from their own bodies. (Examples are hand to mouth, looking at hands, playing with feet.)

4. Stage III. Ask parents how their babies first began to act on things in their environment to achieve pleasureable results. Ask how babies manipulate adults to get them to repeat a fun game or action.

5. Stage IV. Ask parents for examples of ways that babies combine two actions to achieve a desired end. (Examples are rolling over and crawling to get an object, pouring a piece of candy out of a bottle and then picking it up off the table.)

6. Stage V. Ask parents for examples of trial and error behaviors that they have seen their children use in solving problems. Ask for examples of trial and error behaviors that the group members use in solving problems.

7. Ask parents what indications they observe in their children of the use of symbolic thought. (Examples are playing mommy, putting a penny in gum ball machine rather than a quarter.)

Conclusions

From birth infants grow and learn through interactions with objects and persons in their environments. Development proceeds in a sequence from the automatic use of reflexes in very young babies to the use of symbolic thought in toddlers. The sensorimotor schemes that the children use and expand upon become the foundation for later learning and development.

Next Steps

1. A logical successor to this module is the module "How Babies Learn to Think - The Handicapped Child."

2. While working with children and parents on different activities, encourage parents to observe behavior that is indicative of the different stages of development.

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Hunt, J. Intelligence and experience. New York: The Ronald Press Company, 1961.

For More Information

For Leaders

Ginsburg, H., & Opper, S. Piaget's theory of intellectual development: An introduction. Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1969.

For Parents

Lehane, S. Help your baby learn. Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1976.

Pulaski, M. A. S. Understanding Piaget: An introduction to children's cognitive development. New York: Harper Row, 1980.

Sweat, D. A longitudinal assessment of two infants using the Uzgiris-Hunt scales of infant psychological development (videotape). Peabody College, P.O. Box 81, Nashville, Tn. 37203.

SENSORIMOTOR DEVELOPMENT

Stage I — The Reflexive Stage - Infants exercise those schemas or reflexes that are present from birth.

Stage II — Primary Circular Reactions - Infants modify previous reflexive schemas and begin to use two or more of these actions to produce interesting, pleasurable experiences centering around their own bodies.

Stage III — Secondary Circular Reactions - Infants learn to effect changes and receive reinforcement from objects or persons in their environment.

Stage IV — Coordination of the Secondary Circular Reactions - Infants begin to separate "means" from "ends" behaviors to achieve a desired goal.

Stage V — Tertiary Circular Reactions - Infants begin to experiment actively with objects in their environments, and use trial and error to arrive at solutions to problems.

Stage VI — Invention of New Means Through Mental Combinations - At this stage the infants achieve symbolic thought.

COGNITIVE DEVELOPMENT--THE HANDICAPPED INFANT

Jacqueline Bly Sweat

Infants grow and develop cognitively as a result of their interactions with persons and objects in their environments. Development follows a similar pattern in all infants, with previous experiences and learning providing the foundation for more advanced learning. Infants with handicaps appear to follow basically the same pattern of development as nonhandicapped infants; however, rates of development are slower for children with handicaps. Specific handicaps can also lead to problems in learning. Special learning experiences are often needed for children with handicaps to use fully their opportunities to learn.

Objectives

1. Parents will be provided with information about the similarities and differences in the development of cognition in infants with handicaps in comparison to infants without special problems.

2. The group leader will explain the effects that motor problems and sensory deficits have on cognitive development.

3. The leader will describe both general and specific intervention strategies that can be used to minimize the effects of handicaps and to promote cognitive development.

Preparations

1. Remind parents to bring the handout "Sensorimotor Development," which they received during the module "Cognitive Development--How Infants Learn to Think." Have extra copies on hand.

2. Make copies of the handout "How to Help Your Baby Learn," located at the end of this module.

Sequence

1. Use one of the "Ways to Begin" to encourage parents to share examples of their children's cognitive development and to think about the effects of various handicaps on cognitive development. (5-10 minutes)

2. Review briefly the sensorimotor period of cognitive development. (5-10 minutes)

3. Discuss the effects of visual impairments, hearing impairments, and physical handicaps on cognitive development. (10-15 minutes)

4. Discuss general and specific ways to promote cognitive development in handicapped children. Review the handout "How to Help My Baby Learn." Have parents discuss ways in which they have been able to help their children learn new things. (15-20 minutes)

5. Conclusions and next steps. (5 minutes)

Ways to Begin

1. Ask parents whether they have observed and would like to share an example of their children's ability to think since the parent group on "Cognitive Development--How Infants Learn to Think" was held.

2. Being sensitive to the disabilities of children in the group, guide parents in thinking about how various handicapping conditions interfere with cognitive skills or need to be compensated.

   (a) Ask parents who volunteered examples in #1 what difficulty their children might have had doing what they described if their child had been blind, or deaf, or physically disabled or . . . . . .

   (b) Ask parents how their children overcame their disabilities to be able to do what they described in #1.

3. Briefly summarize infant development as described in "Information to Consider." Refer to handout from "Cognitive Development--How Infants Learn to Think."

Information to Consider

Infant Development

In the Module "Cognitive Development--How Infants Learn to Think" parents learned that from birth infants grow and learn through interactions with persons and objects in their environments. Babies receive new information through their senses and process that information in relation to their previous experiences. In this way children are constantly adding to and changing their knowledge of their environment and their means of dealing with it. Newborn infants use those reflexes with which they were born to respond to stimuli in their environments. At first these actions are almost totally automatic, but gradually, as children exercise these readymade schemes, their actions become purposeful, and they begin to act on and learn from their experiences. Jean Piaget, the Swiss psychologist, has described infant development as moving through six different stages, with each stage building upon previous stages. This sequence of development begins with the reflexive behavior of the newborn and culminates in the development of symbolic thought in the toddler. A summary of sensorimotor development can be found in the handout "Sensorimotor Development" from the previous module.

Differences in Development

Researchers have verified that infants do, indeed, follow the sequence of development described by Piaget. However, differences in types of environments and in babies' physical make-up can lead to differences in the overall rates of development as well as to lags in specific areas of development (Hunt, Paraskevopoulos, Schickedanz, & Uzgiris, 1975). For example, in a study of infants in understaffed Teheran orphanages, infants demonstrated slower development in all areas as compared to infants in more stimulating developments. Vocal imitation in particular was delayed. Apparently, infants were receiving little social and verbal stimulation from the overworked staff and therefore were unable to develop those verbal skills that most infants develop through everyday interactions with other persons.

Infants with sensory and/or physical handicaps also may encounter problems with lack of stimulation. Although a particular home environment might be adequate for the development of a child without handicaps, a baby with a handicap may be unable to respond optimally to persons and objects in that environment. Therefore, cognitive, social, and communication development will be affected.

Children with physical and mental handicaps often develop more slowly than other children, spending much more time at one stage before moving to the next. However, the sequence and the processes through which infants develop thinking and reasoning skills appear to be similar for the majority of infants (Guide to Early Development Training, 1972; Connor, Williamson, & Siepp, 1978). Considerable research has been done on the effects of specific handicaps on cognitive development.

Cognitive Functioning of Children with Visual Impairments

Studies have indicated that visual deficits appear to limit infants' abilities to develop concepts about themselves, other persons, and objects in their environments. Blind or severely visually-impaired children often demonstrate difficulties in exploratory manipulation of objects; for example, reach-grasp, and mouthing (Fieber, 1977). Gross motor skills are often also quite delayed, although babies' physical functioning is normal. Blind infants' gross and fine motor skills may be delayed because of (a) the lack of visual stimulation for reaching out or moving toward persons and/or objects and (b) the inability of babies to receive visual reinforcement (by eye contact or facial expressions of caregivers) to repeat actions (Burlingham, 1961). Because blind infants have difficulties in obtaining stimulation from persons and objects in their environments, they often engage in self-stimulatory behavior, for example, rocking or eye-gouging. They focus on their own bodies rather than external stimuli (Fieber, 1977).

Cognitive Functioning of Children with Hearing Impairments

The cognitive development of children with hearing impairments is very similar to that of other children. During the first months of life, vocalizations appear to be reflexive rather than learned behavior. However, after 5 to 6 months there is generally a marked delay in further language development. After the age of about 1 year, both receptive and expressive language skills play an increasingly important role in cognition (DuBose, 1979). (Receptive language is understanding words and concepts, and expressive language is using words.) Both hearing-impaired and visually-impaired children can compensate somewhat by learning through their other intact senses.

Cognitive Development of Children wtih Physical Handicaps

Motor-impaired children (such as children with cerebral palsy or spina bifida) are limited in their abilities to explore their environments. Children with cerebral palsy often retain primitive reflexes longer than children without physical handicaps. These reflexes, which are necessary for normal development, rapidly become integrated into more advanced volitional behavior in most children. However, in children with cerebral palsy, such reflexes often fail to be integrated, and children are unable to break out of these primitive patterns. For example, many cerebral-palsied children retain the asymetrical tonic-neck reflex longer than other children. This reflex causes an arm and leg to extend toward the side to which the head is turned, while the opposite arm and leg will flex. Children who are unable to inhibit or break out of this reflex will be unable to bring an object that they are looking at to their mouths, an action that is one of the earliest forms of object exploration. Children with cerebral palsy often find themselves controlled by primitive reflexes which constantly thwart their attempts to learn from their environments. Children with physical handicaps who are delayed in attaining such major motor milestones as head control, sitting, crawling, and walking are hampered in their physical efforts to explore their environments.

Studies of the long-term effects of motor impairments on the cognitive development of children are inconclusive. Apparently nearly normal development can take place in children with motor handicaps if vision and hearing are intact, even with the absence of object manipulation (Fieber, 1977). Although the physical exploration of objects is very important in early learning, otherwise intact children can compensate for the loss of information through this modality by substituting other forms of exploration, including vision and hearing. The combination of two or more handicaps compounds children's problems because they are less able to compensate for deficits in one area with normal functioning in other areas (Fieber, 1977).

Educational Intervention

While infants with normal development in adequate environments will find ways to explore and learn from their surroundings, infants with handicaps will often require help (Connor et.al., 1978). In providing such help, children's current abilities and levels of functioning should be assessed. Children learn most readily from activities that are neither too difficult nor too easy for them. If a task is too far ahead of their existing abilities, they will be unable to deal with it because they lack the necessary experience to comprehend it. If a task is too simple for them, they may become bored with it, or they may not continue to learn from it.

Children with handicaps often are at a disadvantage in finding a match between their abilities and their activities since they are unable to seek out what interests them. If they are constantly thwarted in their efforts, they may lose their drive to express themselves and to interact with their world. Intervention is designed to provide these children access to appropriate stimulation.

Intervention Strategies

In developing strategies to facilitate cognitive development in children with handicaps, teachers and caregivers should attempt to provide optimal opportunities for children to explore and learn. While direct teaching is the method used most often in working with infants with handicaps, children should be given opportunities to learn on their own, just as other children do (Connor, Williamson, & Siepp, 1978). Opportunities can be provided by arranging children's environments to minimize the effects of their handicaps and to give them access to stimulation. For example, a child with cerebral palsy should be positioned in such a way as to minimize the effects of primitive reflexes and to facilitate existing motor abilities.

Materials for intervention should be chosen based on a child's developmental levels, interests, and physical abilities. For example, sound toys would tend to be non-reinforcing for a deaf child but very reinforcing for a blind child. Children with severe motor handicaps often need toys that require a minimum of physical strength and coordination to operate. For example, although many children with cerebral palsy would be unable to wind the knob on a radio music box, they often can pull the large loop or a modified larger loop on a string-type music box. Other toys that provide maximum stimulation with minimim effort are the Soft Sounds, Gabriel Big Mouth Singers, Flutter Balls, and soft squeeze toys. Toys suspended from a rod over children's cribs or near children on the floor can provide an opportunity to learn. By altering the types and placements of toys, children with different handicaps can be provided with stimulation. Balls, rattles, slinkies, dolls, balloons, and pictures are just a few of the items that can be suspended for children to explore. Positioning children so that they can bat toys with their hands and kick them with their feet can provide opportunities for them to use different motor schemes to receive feedback.

In addition to arranging appropriate learning environments, the ways in which teachers and caregivers interact with infants can help children feel that they can learn and do things. Infants with handicaps often lack opportunities for exercising any systematic control of their environment because of their sensory or physical disabilities. Caregivers often compound the problem by overprotecting children and by providing little opportunity for them to initiate events and control their environment at their own levels. Such children often become victims of "learned helplessness" and can lose the motivation to gain control over objects, events, and persons in their environment (Robinson, 1978). Caregivers can provide materials and activities geared to children's levels of functioning and physical abilities and them allow children time to respond to these stimuli. Caregivers can assist children in learning that they can communicate their needs to other persons. One of the earliest forms of communication can be seen in children who signal their desire for a game to be reinstigated by vocalizing, wiggling, and touching another person. These signals begin as simple responses to stimulation and become communicative as another person consistently responds to them. Caregivers should provide as many opportunities as possible for such social interactions. As children begin to realize that they can effect changes in other persons and objects, they become receptive to exploring means-ends relationships, object permanence, object concepts, and communication.

Questions to Continue Discussion

1. Distribute several toy catalogs. Ask parents to choose toys that would be appropriate for: (a) blind or visually-impaired children, (b) deaf or hearing-impaired children, (c) motor-handicapped children.

2. Ask parents to describe some situations in which their children were able to communicate their needs to them by some means other than spoken language.

3. Ask parents to describe some ways in which learning activities could be modified to their child's present abilities. (For example, how can a finger-play like "The Bumble Bee Song" be adapted to each child's functioning?)

Conclusion

Summarize examples that parents have contributed of their children's thinking processes to illustrate that all children's development follows a similar sequence. Children with handicaps may develop more slowly and may need to compensate for certain disabilities such as blindness or deafness by using their intact senses. Parents and teachers can help children develop cognitively by carefully selecting learning tasks and materials, by arranging children's environments, and by encouraging children's self-expression and initiative.

Next Steps

1. Obtain copies of the Uzgiris and Hunt Scales of Infant Psychological Development and examine the behavior used to test object permanence, means-ends, vocal and gestural imitation, operational causality, spatial relations, and schemes for relating to objects.

2. Explain one or two of the sensorimotor domains listed above. Help parents think of ways to teach their children some of the steps on the Uzgiris and Hunt Scales using functional materials and situations occuring during daily routines.

3. The module, "Social-Emotional Development--Building Trust and Independence" discusses the need for children with handicaps to develop independence, to make choices, and to avoid "learned helplessness."

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How to Help Your Baby Learn

1. Determine your child's present level of cognitive functioning. This can be done through formal testing or through use of a developmental checklist and careful observation.

2. Determine whether your child's inability to respond to a test item or activity is due to cognitive functioning or physical or sensory handicaps. Whenever necessary, adapt the activitiy to enable your child to respond. (For example, rather than have a child with a severe impairment pick up an object to indicate that he knows where it is hidden, have him eye-point to one of two locations.)

3. When presenting an activity, modify the materials as much as necessary. (For example, glue spools to puzzle pieces for easier removal and placement.)

4. Allow your child time to respond. Some children with handicaps require more time than other children to process information, to explore the materials, and to respond.

5. If your child cannot perform a task, modify it to determine at what level the child can perform it. (For example, provide verbal assistance and/or physical assistance, reduce the number of choices, or reposition materials.)

6. Position your child so that he or she is comfortable and able to perform optimally. Provide adaptive equipment as prescribed by physical therapists or teachers. (For example, a child with poor trunk control will also have poor arm and hand use. Providing trunk control through seating or simply by supporting his chest with your arms will enable him to use his hands and arms better to perform an activity.)

7. Provide many opportunities for your child to generalize what he or she has learned. Your child should be able to perform an activity using a variety of materials within different settings. (For example, if a child learns to stack two blocks, she should also be given the opportunity to stack other objects.)

SPEECH AND LANGUAGE DEVELOPMENT

Ann Ballentine Carr

During the first 3 years of life, children have a major task: learning to communicate with important people in their lives. During this time, children learn to comprehend language and to use language to communicate. Children who are handicapped may develop speech and language skills at a slower pace or may need to develop an alternate mode of communication.

Objectives

1. Parents will be provided with information on language development sequence.

2. Parents will be provided with an opportunity to discover where their children are functioning within the language development sequence.

3. Parents will be given information on alternate forms of communication.

4. Parents will receive resources regarding language development.

Preparations

1. Make copies of the following handouts from Parent-Infant Communication (reproduced by permission):

   (a) "Auditory Development in Children"

   (b) "Beginning Words and Phrases"

2. Make copies of "Language Development" handout.

3. Secure materials needed for the session: blackboard, chalk, picture or actual example of communication board, tape-recorder (optional).

4. Optional:

   (a) Order "Looking at Language Learning" poster. (Available for $1.00 from Intersect, 1101 17th Avenue South, Nashville, TN 37212, telephone: 615-327-2948.)

   (b) Tape-record a short language sample of children in as many of the following stages as possible: crying, cooing, babbling, jargoning, one-word, two-word, and three-word sentences.

Sequence

1. Select one or more of the "Ways to Begin" to help parents think about how children develop language. (5-10 minutes)

2. Provide information regarding receptive language development. Discuss the three stages delineated in the "Auditory Development in Children" handout. (5-10 minutes)

3. Ask parents to read the information in the handout "Speech and Language Development." Summarize the various expressive language stages. Provide parents with an example of each stage, either by demonstration or by playing a section of the taped language sample. (10-15 minutes)

4. Ask parents to recall their children's first words and try to locate them on the "Beginning Words and Phrases" handout. Ask parents to share the first words of their children with each other. Write the children's first words on the blackboard. (Note: The group leader should be sensitive to the possibility that not all of the parents' children will have reached this language stage. The group leader might ask these parents questions such as "How does your child let you know that she wants something?" The answer to this questions can be explained as beginning communication and as important precursors to the one-word language level. (5-10 minutes)

5. Briefly discuss speech development. (5 minutes)

6. Discuss alternate forms of communication. Provide examples of these modes. (5 minutes)

7. Choose questions from "Questions to Continue Discussion" to help parents identify in which stage of language development their children are functioning and how they can help their children to progress in their language development. (5-10 minutes)

8. Conclusions and next steps. (5 minutes)

Ways to Begin

1. Ask several people in the group a question in a foreign language (for example, "Ou est la fenetre?" "Where is the window?") Continue additional conversation if you want or are able. If the question is unanswered (which it probably will be), then answer the question. ("Ah, voila, la fenetre!" "Here is the window!") Then ask parents several of the following questions: "Did any of you understand me?" "How did you feel when you didn't understand me?" "What did you know about what I was saying without even understanding the words?" ("Was I mad?" "Was I questioning?") Point out the similarities of this experience with babies, or young handicapped children's experiences with language learning.

Ways to Begin (continued)

2. Distribute the handouts and invite parents to look at them. Participating in any discussion that occurs may help the leader discover what areas of language development parents are particularly interested in and have questions about.

Information to Consider

Children with handicaps are often delayed in their language development. One of the major concerns of many parents who have handicapped children is language--wanting their children to learn to talk or to learn to talk more clearly and fluently than they do. Usually, language intervention goals are planned to assist children in developing language according to a normal developmental sequence. If parents are familiar with the normal language sequence, they can better pinpoint problems and understand language programming.

Receptive Language Development

Language development begins with children's awareness of sounds in their environments. As early as 3 days old, infants can orient to a sound (Brazelton, 1973). Children who cannot hear cannot develop language. Therefore, hearing losses should be diagnosed as soon as possible. (Children's hearing can be monitored by a pediatric audiologist or an ear, nose, and throat specialist.)

By 4 to 6 months of age, most children can turn their heads toward the source of a sound (Northern & Downs, 1974). Although children cannot understand words much before 6 months, they do pay attention to how the words are spoken. Children between 2 and 4 months will respond differently to angry and friendly, familiar and unfamiliar voices (Kaplan & Kaplan, 1970), marking the beginning of early word recognition skills. They are paying attention to inflection, or how the words are spoken.

At approximately 6 months of age, children begin to recognize words such as "bye-bye," "mama," and "hot" (Bzoch & League, 1971). Children also begin to recognize their names. Comprehension of words is a prerequisite skill to meaningful use of words.

Having mastered awareness and recognition of sounds and words, children next begin to understand simple questions such as "Where is the ball?" at 11 months of age (Bzoch & League, 1971). They also often follow a verbal request, such as "Give me the ball." By 18 months of age, children can comprehend two consecutive directions ("Bring me the ball and close the door.") They also can identify simple body parts ("Point to your nose"). Having mastered all these receptive language skills, usually by the age of 2, children begin to enjoy having books read to them.

Expressive Language Development

Expressive communication skills begin with the birth cry. Soon after, children begin to cry and vocalize in different ways. Parents may be able to distinguish between the "I'm wet" cry and the "I'm hungry" cry. Children also begin smiling in response to their parents' smiles. Between 2 to 6 months, children develop cooing sounds. Cooing sounds are composed primarily of vowel sounds (for example, "ah" "ee").

Children next babble by putting consonant sounds and vowel sounds together and repeating them over and over (for example, "mama" "dada"). Children 6 to 9 months of age also combine sounds in different combinations ("dadamada"). During this period, babbling tends to increase as people babble sounds back to a baby (Bangs, 1979).

By 9 months of age, children also have mastered some gesture language. They may shake their heads "no," reach for people or objects, and extend their arms to be picked up in response to a gesture from an adult (Langley, 1976).

At 9 to 15 months of age, two changes occur in children's language. The first change is that children begin to jargon. During the jargoning phase, children talk using the rhythm, stress, and inflectional changes of a language, but the combination of sounds is meaningless to the listener (Bangs, 1979). Parents often report that their children sound as if they are talking in another language. The second change in children's language is that their first words appear.

Pointing becomes a communicative gesture at 17 months of age. Children will continue to use pointing in addition to words until they become proficient in verbal language.

Between 18 months and 2 years of age, two-word phrases begin emerging, for example, "Mama juice." Two-word phrases can assume a variety of meanings. For example, "Mama juice" could mean "I want juice" or "Mama spilled the juice." The context determines the meaning. Children's expressive vocabulary increases dramatically during this time. By 2 years of age, children have a vocabulary of approximately 200 words (Berry, 1969).

By 3 years of age, children have a vocabulary of approximately 440 words. The sentences that a 3 year old uses also expand to three and four words, for example, "I want juice" or "Mama, daddy go bye-bye."

Speech Development

Language is concerned with the understanding and communication of concepts and ideas. It is <u>what</u> you say. Speech development is concerned with the quality of the talking process, or <u>how</u> you say it. Some questions to be answered when looking at the quality of children's speech: "How well does she articulate her sounds?" "How well does he use his voice to talk?" "How smoothly does she talk?" Children develop language skills before they master speech skills.

Articulation. Children learn to master pronunciation of sounds in a developmental sequence. For example, a child can articulate a "b" sound before an "s" or "r" sound. By 3 years of age, 75% of children with normal development pronounce the following sounds correctly: "m," "n," "h," "p," "b," "t," "d," "k," "g," "w." It is not until 4 years of age that 75% of children can correctly pronounce an "s" and "r" sound (Berry, 1969). Children should be fairly easy to understand by 3 years of age.

Voice. Some handicapped children have problems with their voice. These problems may include atypical voice pitch (voice may be too low or high), intensity (voice may be too loud or soft), and quality (voice may be hoarse, hyponasal--sounds like a person with a cold, or hypernasal). Children whose voices sound atypical may need to be seen by an ear, nose, and throat specialist, and a speech pathologist to find out what is influencing their unusual voice quality and what intervention might help.

Fluency. Stuttering is defined as repeating and/or prolonging sounds in words. When some young children are first learning to talk, they may repeat whole words over and over ("Daddy, Daddy, Daddy, I want the ball"). Parents may be concerned about their children's developing stuttering patterns, but a stage of repeating words over and over is not uncommon. This stage is not considered to be stuttering, and usually, children gradually stop repeating words. Parents should be encouraged to wait patiently for children to express themselves and avoid drawing attention to the word repetition. Speech pathologists can answer parents' questions about stuttering.

Alternate Forms of Communication

Verbal communication is not always a viable option for children with handicaps. After careful evaluation and diagnostic teaching, intervention specialists and parents may decide that a child needs another means of communication.

In some cases, an alternate communication system can actually facilitate verbal communication. For example, children who are having auditory memory problems may have trouble remembering words. Sometimes these same children can remember words better when they learn a sign as well as a word for a particular object.

Sign language, communication boards, and talking machines are examples of alternate forms of communication. Sign language is spoken by using specific motions of the hands. Each manual gesture has a meaning associated with it. Communication boards are composed of pictures or drawings that are arranged on a surface. Children indicate which picture communicates their needs by a hand gesture (such as pointing), an eye gesture (directed gaze), or a head gesture (used with a headstick).

Questions to Continue Discussion

1. Ask parents which skills they think that their children have already learned in understanding language. (If one person volunteers an answer to this question, the group leader may continue parent participation by asking, "Whose child is also at this stage of understanding?") Ask what their children need to learn next.

2. Ask which stages of talking their children have achieved. Ask which stages they need to learn next.

3. Ask parents how their children let them know what they want.

4. Ask parents when their children talk most frequently. (For example, when they are playing by themselves? When they want attention?)

Conclusions

Language learning has many different components: the development of non-verbal communication, such as eye contact and gestures; the development of receptive language, such as awareness and understanding of sounds, words, and sentences; and the development of expressive language (talking, signing, or use of a communication board or talking machine). Each child has mastered certain language skills and needs to master other language skills in the developmental sequence.

The "Looking at Language Learning" poster summarizes the language development sequence. Post it somewhere in the room for the parents' future reference.

Next Steps

1. The "Rules of Talking" module is a natural successor to the "Speech and Language Development" parent module.

2. Include books in the parent library that discuss language development, as well as language development techniques. Lists of references for parents are included and in the "Rules of Talking" module.

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Speech and Language Development

The First Year of Life

1. A baby's first sound is the birth cry. Soon after, babies cry in different ways for many different things. For example, parents may be able to tell the difference between the "I'm hungry" cry and the "I'm wet" cry.

2. Between 2 and 6 months, children learn to coo. Cooing sounds are composed of vowel sounds ("ah," "ee"). Parents can encourage their baby to make cooing sounds more often by listening to, playing with, and/or comforting their baby when such sounds are made. Responding to a child's attempts to communicate will encourage language at other stages as well.

3. Next, children learn how to babble. Babbling sounds are composed of consonant and vowel sounds ("mamama"; "bababa"). Parents can encourage their children to make babbling sounds by repeating the babbling sounds back to their child.

4. At 9 months, children move into the jargoning stage. A child who sounds like she's talking in a foreign language is in the jargoning stage of talking.

5. Children may say their first words from 8 to 18 months, with the usual age at 11 months.

The Second Year of Life

1. Children begin to use words meaningfully (that is, understand much of what adults or older children say; use the right words or some sound very much like the word to ask for things).

2. Between 18 months and 2 years of age, children use two-word sentences. ("Mama juice"; "I go").

3. When a parent says a sentence, a child usually copies one or two words of the sentence.

4. A 2-year-old has a 200-word vocabulary.

The Third Year of Life

1. A 3-year-old child can use three-to four-word sentences (for example, "I want juice").

2. A 3-year-old child has a 400-word vocabulary.

3. By 3 years of age, many children can correctly pronounce the following sounds when they talk: "m," "n," "h," "p," "b," "t," "d," "k," "g," "w".

BEGINNING WORDS AND PHRASES

OPEN	STOP IT	OFF
open the door	you stop it	turn it off
open the box	stop it right now	take it (clothes, shoe) off
the window's open	stop the (car)	the light's off
open your mouth	stop	

UP	HOT	ALL GONE
stand up	it's (that's) hot	it's all gone
put it up	hot coffee	your milk's all gone
lift you up	the water's hot	
get up		

MOMMY	MORE	DADDY
where's Mommy?	more juice?	Daddy's sleeping
Mommy's tired	more milk?	Daddy's at work
Mommy busy	no more	come here Daddy
that's Mommy's	you want more?	there's Daddy
(call) Mommy!		(call) Daddy!

You will use other words throughout the day and some of these will be among the first learned by your child:

bye-bye	oh-oh	him
no	round and round	mine
come here	night night	me
hi	move	look
down	cold	wait
on	push	help me
ow	pull	there
ok	put it there	

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AUDITORY DEVELOPMENT IN CHILDREN

There are three major stages in the development of auditory perceptual skills. By becoming familiar with each of these stages, you can tell at what stage/stages your child is operating and help him move to more advanced stages.

I. **Awareness** of sound: The child notices that a sound has occurred. He may blink, stop moving for an instant, or look up trying to see what made the sound.

II. **Recognition** of sound: When the child is aware of sounds he begins to pay more **attention** to the same sounds that he hears again and again. He begins to notice that sounds are not all the same, that noises sound different. We say he **discriminates** between sounds when he can tell the difference between sounds. Some of the sounds that the baby pays attention to and discriminates begin to mean something to him. He realizes that the sound of footsteps means mother or father is walking nearby. He begins to **recognize** sounds. He attaches the sound to the source that makes it. One of the first sounds a baby recognizes is his mother's voice. Very young babies are comforted by the sound of their mother's voice because they recognize her voice.

III. **Comprehension** of sound: When a baby recognizes a sound, the sound begins to convey meaning to him and he begins to act. The sound of footsteps means that someone may be coming to pick him up, so the baby begins moving and extends his arms up. The sound of food being stirred makes the baby smack his lips and crawl to the high chair. When the baby **comprehends** sound, he understands what it means. One of the most complex sounds a baby learns to comprehend is the series of sounds we call speech. When the baby comprehends speech sounds we say he has developed receptive language. Obviously, **memory** is involved in recognition and comprehension of speech, since if a baby could not remember having heard a sound before he could not learn to recognize or comprehend it.

The development of listening is the same for a hearing impaired child as for a hearing child. As you can see, a child must learn to understand certain things about sound before he moves on to the next developmental level. You know that your child's first response to sound was **awareness**. What did he do? Then you later noticed him actually listening to sound and he seemed to be thinking about it. He was giving more attention to sound. He had to pay attention to sounds for a considerable period of time before he actually learned to **recognize** some sounds. And finally, he began to realize that some sounds meant something in particular - the baby began to **comprehend** sound.

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SOCIAL AND EMOTIONAL DEVELOPMENT--

BUILDING TRUST AND INDEPENDENCE

Elizabeth Gerlock

During the first 3 years of life, children learn to trust their caregivers and begin to assert their independence. Infants with handicaps may have problems accomplishing both these tasks, but their parents can help them build trust, learn to make simple choices, develop some independence, and begin to develop a positive self-concept.

Objectives

1. Parents will understand ways their children learn to trust.

2. Parents will understand their children's need for independence.

3. Parents will discuss ways to help infants and toddlers with handicaps assert their independence.

4. Parents will plan opportunities for their children to make choices.

Sequence

1. Have group members share experiences that show successes and difficulties in their children's development of trust as suggested in "Ways to Begin." (5-10 minutes)

2. Present information about the development of trust and the difficulties that children with handicaps and their parents may have adjusting to each other. (5-10 minutes)

3. Choose questions from #1-3 in "Questions to Continue the Discussion." (10-15 minutes)

4. Present information about the development of independence and the importance of allowing children to make choices. (5-10 minutes)

5. Choose "Questions to Continue the Discussion" from #4-9. (10-15 minutes)

6. Conclusion (5 minutes)

Ways to Begin

1. Ask parents how they think that their children learned to trust them and to depend on them.

2. Ask parents to share experiences of having children in the hospital. Ask how their children knew that they had not abandoned them.

3. Describe a problem situation (such as a blind baby, a baby who cries all day, or a spastic child). Avoid disabilities or problems that children in the group have. Ask what might interfere with a mother and child becoming attached.

Information to Consider

Ways Babies Learn to Trust

Babies learn to trust and depend on their caregivers in a number of ways. Babies gradually develop trust as they learn that someone comes when they cry, that someone feeds them, changes them, and makes them comfortable. They learn that they can depend on a special person in their world to take care of their needs. Mothers learn that they are capable of satisfying their babies and making them happy. They learn the satisfaction of easing the babies discomfort, and they are amply rewarded with smiles, cuddling, and gurgling.

Possible Problems That Interfere with the Establishment of Trust

Researchers believe that early bonding or attachment between caregivers and children is crucial for the enotional development of children (Klaus & Kennell, 1976). With handicapped babies, many difficulties may interfere with the mutually satisfying interactions between parents and child. Connor, Williamson, and Siepp (1978) discuss some of the problems. There may be no eye contact and smiling because a child is blind. A baby may not be able to adjust her body to be cuddled because she is spastic as a result of cerebral palsy. Parents may not be able to soothe and satisfy their baby because of complicated medical problems. Feeding may be a struggle because of a poorly developed ability to suck or other problems that interfere with eating. Parents may doubt that they are capable of satisfying the needs of their handicapped child. They may be in a state of emotional upheaval--angry, grief-stricken, and despondent--making them less capable of responding to their baby's early cues.

Both parents' responses and a baby's responses are essential for establishing the emotional relationship between them. Parents find it difficult to avoid rejecting a handicapped baby, responding only enough to satisfy basic needs and keeping their baby away from other people in their grief and anger, especially if the disability is obvious and severe (Connor et al., 1978). A child may have to be hospitalized, causing periods of separation, anxiety, and grief that further interrupt the parent/child interactional process.

Solutions. Parents can be helped to learn and better understand their blind or spastic child's body signals. Parents of blind infants sometimes need assistance in reading their child's signals, which may be expresssed through the hands, in order to respond appropriately to their child. Without looking at the hands, parents may interpret the blank look and absence of a smile as indicating boredom, depression, and unfriendliness in their child (Fraiberg, 1974). Parents' presence during hospitalization, treatment, and other traumas may help to ease their child's stress and facilitate the development of trust. At times, babies may seem to appeal to parents to save them from an ordeal, only to have parents deliver them into the hands of their tormentors (doctors, nurses, therapists). However, where trust has been established, parents report that trust can withstand many difficulties.

Helping parents identify difficulties in their relationship with their baby is the first step toward developing a better relationship. Professionals can help promote the social development of handicapped children by involving parents in all educational and treatment programs and by being sensitive to the parent/child attachment.

Development of Independence

Erikson (1963) states that the major emotional developmental task of the first year of life is the development of a sense of trust (versus mistrust). The task of the 2nd and 3rd year is to develop a sense of autonomy (versus shame and doubt). Autonomy refers to independence, or self-reliance. Toddlers begin to say "no" to reasonable requests such as "Come to dinner" or "Put on your coat." They conduct endless experiments with their environments. "I wonder what will happen if I tip the sugar bowl a little more. . .and still more." "How angry will she be if I continue to go this way while she is calling me to come back?" Many children seem bent on refining their skills of frustrating, aggravating, and infuriating their caregivers. At least some part of the explanation for toddlers' defiance is their need to establish themselves as independent human beings: "He seems to realize that he's not meant to be a baby doll the rest of his life, but a human being with ideas and a will of his own" (Spock, 1957).

At the same time that children are expressing their realization that they are independent human beings, they also are feeling fear of separation (Brazelton, 1974). The developmental period from 1 to 3 years is a difficult time for both children and adults, and more so for some than for others: "But if parents can see it as a vital bridge to the next set of achievements, and not just an assault on them by a miserable child--it may be easier for them to participate with pleasure as well as pain" (Brazelton, 1974).

What happens with handicapped children who cannot move about to assert their independence? In some cases, children's physical dependence and the degree of their disabilities may slow down their demand for independence. In other cases, children may exhibit their need for autonomy in any way that they can, such as spitting their food, slapping their mothers, or throwing things. While such behavior cannot be

permitted, parents can be helped to understand that their children may be feeling a need to assert themselves. One severely physically handicapped little girl began to cry when her father took care of her. While this behavior was quite distressing to him, it showed that she was differentiating between people and asserting her independence.

Often parents try to shield their children with disabilities from experiences that they fear may result in failure, frustration, or physical pain. At the same time they may treat them as they would a younger child and not allow them to use the skills that they have developed. Sometimes doing things for children with handicaps is much easier than having them try to do things independently (Connor et al., 1978). However, these children need to learn to assert themselves, do what they can for themselves, and become as independent as possible.

Providing Opportunities for Making Choices

Seligman (1975) describes a state of "learned helplessness" in which children who have had everything done for them, with no opportunity to control their environments, learn to continue to be helpless and do not try to do things for themselves. To avoid "teaching" helplessness parents and teachers of severely disabled children can seek ways to allow children to make choices; for example, they can develop a signal to indicate "yes" and "no." Even such a small accomplishment as hitting a mobile to hear a bell ring gives children a small sense of control over their environments, which is crucial for learning and for developing self-concept. When children are young, they will view themselves as their parents see them. If parents see their children as helpless, children will think of themselves as helpless. If parents see them as worthwhile and able, children will adopt that perspective themselves (Bigge, 1976).

All children need an opportunity to learn to make choices and to make decisions: "If a child is to develop a meaningful sense of autonomy, it is necessary that he experience over and over again that he is a person who is permitted to make choices" (Erikson, 1963). When an opportunity for a choice is presented to a child, all the alternatives must be acceptable to the parents and the choice must be within the child's ability (Knox, 1978). For example, a parent might ask, "Would you like to watch TV or go outside?" The opportunity to make choices creates an atmosphere that encourages development of communication skills as well as independence. Begun at an early age, allowing a child to make choices establishes a pattern of interaction between parent and child that communicates: "I respect you as an independent person capable of making decisions. I will be here to help you, but I want you to be as independent as possible and I want your life to be as fullfilling as possible." Such an attitude and relationship can be developed gradually as children become able to do things for themselves.

Handicapped adults have written of the shame, self-doubt, and loss of self-respect that lack of opportunities to act independently brought them (Bogdon, 1978; Connor et al., 1978). One mentally retarded young man who was interviewed by Bogdon and Taylor (1977) about his life expressed the need that he felt as a child to be like everyone else. Because of his

precarious hold on life as an infant, his mother had an understandable need to protect him as a growing child. She watched him constantly and ran to him whenever he yelled. He felt she protected him after he was capable of being self-sufficient. He said, "Sometimes I think the pain of being handicapped is that people give you so much love that it becomes a weight on you and a weight on them." Connor et al. (1978) stated that disabled adults nearly always list lack of independence as a problem in childhood. Even at age 2 or 3, disabled children can be allowed to try new experiences, to learn to cope with failure, and to make choices (Connor et al., 1978; Bigge, 1976).

Questions to Continue the Discussion

Questions should be developed to respond to the needs of the group. Some sample questions are listed below.

1. Ask how parents can develop attachment and trust when their baby fusses and cries most of the time.

2. Ask how parents and extended family can provide emotional support for a baby during periods when intense medical treatment is required. Ask how they support each other.

3. Ask how children of families in the group react to doctors and hospitals. Ask how trust is important when children are afraid of doctors.

4. Ask what things children in the group are doing to express their independence.

5. Ask for examples of ways young children with handicaps can be given an opportunity to make choices.

6. Ask how young children in the group let parents know what they want.

7. Ask what new experiences children in the group have tried. Ask how they reacted.

8. Ask what parents envision in the future for their children. Ask how independent they think that they will be able to be.

9. Ask parents if they have experienced having someone tell them everything to do or doing everything for them. Ask how they felt. Ask how they feel when they plan a task or activity for themselves and carry through with it. Ask which of these feelings they want to work toward for their children.

Conclusion

Summarize some of the ways that parents in the group have achieved success in establishing trust and autonomy with their child.

Parents, teachers, therapists, and doctors are all working to minimize to whatever degree is possible the problems of a handicapped infant. In working to educate, to provide needed medical care, and to develop physical abilities, parents and teachers must not overlook a child's emotional needs--the need to feel, "I can trust and depend on those I love to be there when I need them. I am a person of worth and dignity. There are things I can do by myself. I can cause things to happen in my world. I am somebody!"

Next Step

Ask an adult with a handicap who functions fairly independently to discuss how he or she developed independence in spite of this handicap and how parents encouraged or discouraged independence.

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SELF-CARE SKILLS

Maria N. Donofrio

The concept of self-care integrates skills from all areas: gross and fine motor skills, thinking and planning skills, and social skills. A child's self-image is enhanced by mastery of eating, dressing, and toileting skills. Many of these complex activities have their beginnings in infancy. One of a parent's first jobs is to teach children independent self-care behavior.

Objectives

1. Parents will be able to trace the origins of self-care skills.

2. Parents will discover the implications of self-care mastery for their children and themselves.

3. Parents will learn some general considerations for teaching self-care.

Preparation

1. Make copies of the worksheet on general self-care information (optional). (See handouts at end of this module.)

2. Make copies of "Self-Help--Feeding" and "Self-Help--Dressing" and lists of suggested equipment. (See handouts at the end of this module.)

3. Collect materials: blackboard and chalk, or newsprint pad and markers.

Sequence

1. Choose one of the "Ways to Begin" to help parents understand how self-care begins in infants and develops gradually in the growing child. (5 minutes)

2. Present basic self-care including the difficulties encountered by children with handicaps and the many skills required for self-feeding, dressing, and toileting. (15-20 minutes)

3. Discuss self-care as it applies to parents and children in the group. (15-20 minutes)

4. Conclude by incorporating thoughts that parents shared in discussion with the major points of the presentation. (5-10 minutes)

5. Choose a next-step procedure to follow through on the new information.

Ways to Begin

1. Ask parents to think about their daily routines. Ask them how they physically care for other people.

2. Ask parents to think about infants. Ask them how infants help their parents in the daily care they provide.

3. Ask parents to think about their own children. Ask them about their children's responsibilities.

4. Ask parents to think about growing children. When do they see the first signs of independence in children?

5. Distirbute "Self-Help--Feeding" and "Self-Help Dressing" and the lists of equipment. Ask parents to check the items on both sheets that their children can do.

Information to Consider

Self-care--Independence in Action

The daily activities of dressing, eating, and toileting are the first self-care activities that children acquire. Before most children entèr school or even some preschool programs, they ususally show beginning mastery of these skills. These skills are usually taught by parents since the home is the natural setting for self-care skills. Parents perform or monitor care-taking tasks several times a day with their children.

In addition to the practical benefits of personal-care achievements, self-care development is regarded as an important component in a child's independence (Bigge, 1976; Coley, 1977; Linde, 1973; Snell, 1978). The word "independence" conveys many meanings. For young children, self-care skills impart elements of self-sufficiency, capability, responsibility, and decision-making. Concrete behavior such as finger-feeding, pulling up pants, or going to the bathroom on a commode annouce to the world that this person is taking care of himself. In these everyday occurrences, growing independence of action accompanies growth in self-awareness.

Self-Care Skills for the Handicapped Child

Families of children with handicaps are also expected to help their children learn self-care skills, but they often confront many obstacles. Children may be dependent on others for their physical needs for a longer period of time. With some handicapping conditions, self-care

skills may take longer to learn, may need to be adapted, or may need to be taught through special techniques. Children with physical handicaps may have difficulty in using their hands to feed themselves. Visually-impaired children, who cannot see the steps involved in dressing, may need special guidance in learning to dress themselves. A child who cannot walk will need special arrangements for toileting. Some children may always need help with some tasks.

With prolonged dependency, parents are faced with balancing children's continuing physical dependence and children's need for independent choices and independent actions (Connor, 1978). Feelings of protectiveness are natural for parents and conflict with their desire to see their children achieve independence (Coley, 1977). All children can gain some independence--independence appropriate to their levels of development. The challenge for parents and teachers is to find which skills are suitable for the developmental levels and physical abilities of their children. Nancy Finnie, a well known authority on the development of self-care skill, maintains that children learn either to help themselves or to lie helplessly (Finnie, 1976).

Beginnings of Self-Care

Parents intuitively start the concrete teaching of self-care skills toward the latter part of the first year of life when children's many capabilities are increasing. The eating skills of cup-drinking and finger-feeding are often thought of as the beginning of the self-care process. Children at this stage are learning to drink rather than suck, and their newly acquired ability to pick up small objects coincides with their finger-feeding.

However, the development of self-care skills does not begin abruptly during the latter half of the first year. Coley (1977) maintains that the process starts at birth and lasts throughout life. The first element of self-care development is the ability to visually track objects or people. Later children add the motor skills of reaching for and finally of grasping objects. For example, an infant visually tracks a bottle as it is brough toward her and taken away. Eventually she will reach for the bottle, and finally her hand rests on it as she sucks. A child with visual impairment must use touch, sound, and smell as cues in developing self-care skills.

Infants begin to recognize objects that are part of everyday routines, such as diapers, spoons, or shirts. This recognition is a combination of developing cognitive or thinking skills and awareness of socially appropriate actions. When children recognize a spoon and respond by opening their mouths or by turning away, the self-care process is on its way. Later, young children begin to see the individual steps that are part of a chain of events that lead to a full stomach, dry pants, or dressing for the day.

With the ability to recognize objects and to reach and grasp them, children start to imitate what others do with objects during the daily routine. Children at very young ages learn by seeing, then by doing, and

parents are their models. Children imitate actions that they see and begin to help with parts of self-care tasks, and finally they do parts by themselves. Children need to go through these tasks many times before they begin to assume an active part. Children with handicaps learn the same way; they have difficulty imitating the actions, may have to perform the task differently, or may take longer to learn them.

Motor Planning

Feeding, dressing, and toileting are complex tasks requiring multiple skills including motor behavior, thinking or cognition, and social awareness (Snell, 1978). The integration of skills learned in many easier tasks involves motor-planning--that is, giving one's body correct directions. For a child, such planning is often directed by parents (Coley, 1977). In addition to learning discrete steps in a task, children must learn to plan the sequence of steps in a task.

As teachers of their handicapped children, parents should view the major accomplishments of toileting, dressing, and eating as beginning in simple behavior in infancy. By breaking down these major goals into more easily achieved intermediate levels, both children and parents can establish realistic expectations of success. This may reduce the frustration sometimes experienced in teaching self-care skills. Knowing the small steps that are part of self-care sharpens parents' ability to ask for increasingly more participation from their children in these tasks while maintaining realistic expectations.

Teaching Self-Help Skills

Baker, Brightman, Heifetz, and Murphy (1976) in their Steps To Independence series describe the skills prerequisite for structured teaching of self-care tasks. They summarize them in four easy conditions: (a) children must be able to pay attention, respond to their names, look at their parents and hear and/or see what their parents are doing; (b) children must be able to follow simple commands, for example, look at an object, place an object; (c) children must be able to follow simple directions with objects ("Take the spoon, Jenny"); (d) children must be able to imitate actions with objects ("Scoop with the spoon like this, John").

In order for parents to begin structured teaching of self-care skills, they need first to decide which skills their children are ready to learn based on prerequisite behavior or skills that their children have already mastered. Second, they must set aside extra time during their day to devote to training.

Once both parents and children are ready, tasks should be taught in a succession of easy steps. Start with a step that the children can already accomplish without frustration. This allows parents and children to experience success. Gradually, newer and slightly more difficult steps can be introduced after children handle the earlier ones with confidence.

Choosing an activity and the first step of that activity may be difficult at first. Select an activity that is important for children to learn that both parents and children are interested in and can enjoy (Baker et.al., 1976). The use of reinforcement or rewards such as praise or hugs (and for some children, tangible reinforcement such as food) also adds to children's motivation to complete a task.

Questions to Continue Discussion

1. Ask parents how their children show that they want to do things their own way. Does this ever occur during care-taking activities?

2. Give parents a self-care task such as finger-feeding or putting on a shirt. Have parents divide the skill into small steps and list these steps on a blackboard or newsprint pad. Ask parents to identify their children's skill levels within the progression of steps.

3. Ask parents whether their children appear to be frustrated when they are attempting self-care activities. Ask how they deal with their children's frustration.

4. Ask parents when they feel frustrated in providing care-taking tasks for their children.

5. Ask parents whether they see themselves as the only teachers of self-care skills. Ask how other family members (for example, brothers and sisters) could be involved.

6. If parents dress their children, ask them to describe the process. Ask whether their children help during the dressing routine, and if so, how they help.

7. Ask parents to describe examples of their children asserting their independence (making choices). (For example, during dressing--choosing what to wear.)

8. At times children resist doing certain things. (For example, they do not cooperate in diapering.) Ask parents how they view the resistance and what they do about it.

9. In the parent guide, Handling the Cerebral Palsied Child at Home (1976), Nancy Finnie cautions parents about providing too much help for a handicapped child. Ask parents how they feel about Nancy Finnie's view.

Conclusion

In reviewing the major points of the information presented on self-care, integrate the thoughts parents developed during the discussion session. This session is a general overview and does not provide specific techniques for parents to use in teaching self-care skills; rather it is a foundation for teaching of self-care tasks. The contribution of the parents' individual examples should provide rich ideas for expanding the topic into a discussion of teaching techniques. Many difficulties are

encountered in the care-taking of handicapped children, and the sharing of success and problems in this session should provide support for parents.

Next Steps

1. Ask parents to observe their children for one week during care-taking. Ask them to look for prerequisites to structured teaching of self-care skills. (For example, note whether their child visually attends to eating cereal or putting on shoes and socks.)

2. The general overview on self-care can be followed by specific techniques for teaching skills in toileting, eating, or dressing.

3. Questions or comments on resistance or other problems could lead to a parent group on behavior or discipline.

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SELF-CARE SKILLS

1. Self-care skills may be some of the most important behaviors for children to learn. Children use these skills every day, and they may be one of the first steps to independence.

2. What are self-care skills?

Eating Dressing Toileting Bathing Grooming

3. When are parents and children ready?

Parents Readiness	Children's Readiness
a. Some free time	a. Looking when called
b. Observation of child's present skills	b. Following a simple command
c. Decision about skill area to be taught	c. Following a simple direction with object
	d. Imitating actions

4. Choosing the activity:

Select an activity that (a) you feel is important for your child to learn now, and (b) you feel you will both enjoy and are interested in doing.

Select an activity that your child:

a. Pays attention when you do it;
b. Tries to help with;
c. Tries to continue when you stop part-way;
d. Does in a similar manner in a play situation.

5. Teaching the task:

a. Simplify the activity.
b. Teach the activity in small steps.
c. Select a time and place for teaching the activity.
d. Teach the activity where the behavior occurs naturally when possible.
e. Use simple, familiar words. Use gestures.
f. Be consistent.

SELF-HELP--FEEDING

0-6 Months

1. Resists textured foods.
2. Sips from cup.

6 Months-1 Year

3. Accepts some non-liquid foods (cereal), but not lumpy foods.
4. Imitates protrusion of tongue--a voluntary sticking out of tongue. (A cerebral palsy tongue thrust is not scored as passing.)
5. Accepts and swallows some lumpy foods (cottage cheese, mashed foods; no meat or raw vegetables). Eats some dry finger foods.
6. Holds spoon, holds own bottle; will pick bottle up, if desired, and finish it.

1-2 Years

7. Attempts to hold cup to drink, using 2 hands.
8. Allows adult to manipulate him or her through feeding while holding spoon.
9. Chews and swallows small pieces of solid food.
10. Fills spoon, inserts in mouth with considerable spilling.
11. Holds cup with both hands, apt to tip too quickly and spills liquid.
12. Uses spoon, spilling little.

2-4 Years

13. Eats finger foods independently.
14. Feeds self with spoon independently.
15. Drinks from cup and returns it to table without spilling.
16. Eats at table without requiring too much attention. Needs help with food preparation and monitoring for problems.
17. Begins to pierce food with fork rather than scooping.
18. Holds glass steadily in 1 hand. Pours from pitcher with assistance. (Must pass both items.)
19. Feeds self independently.
20. Drinks from cup neatly. Holds cup by handle.

4-6 Years

21. Uses fork appropriately and easily.
22. Pours from another container, refilling glass.
23. Helps set table by placing silverware and napkin in close approximation to appropriate placement.

24. Conforms to appropriate table manners—uses napkin.
25. Uses knife to spread.
26. Accepts and chews table food of a variety of textures and temperatures (food may be cut up or fork-mashed, but not ground).
27. Eats most sandwiches with minimal loss of contents.
28. Prepares simple foods with minimal assistance if no measurement is required. (Puts cereal in bowl and adds in appropriate amount of milk; or spreads butter on graham cracker or slice of bread.)

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SUGGESTED EQUIPMENT LIST FOR SELF-HELP - FEEDING

0-6 Months

Textured, non-liquid food, e.g., cereal
Cup with milk or other liquid

6 Months-1 Year

Non-liquid foods, e.g., cereal
Lumpy foods, e.g., cottage cheese, mashed foods
Finger foods, e.g., pretzels
Spoon
Bottle with milk or other liquid

1-2 Years

Cup with milk or other liquid
Spoon
Solid food, cut up

2-4 Years

Finger foods, e.g., pretzels
Spoon
Cup with milk or other liquid
Table food
Fork
Glass with milk or other liquid
Pitcher or carton with liquid for pouring
Cup with handle

4-6 Years

Fork
Glass
Pitcher or carton with liquid for pouring
Table food
Napkin
Knife
Sandwich
Bread and butter

Project APT, Fairfax, Virginia

SELF-HELP - DRESSING

0-6 Months

1. Resists dressing.
2. Raises hips for diaper change.

6 Months-1 Year

3. Exhibits less resistance to being dressed and undressed.
4. Assists in undressing; helps in final motion.
5. Takes off hat and socks.
6. Cooperates in dressing-holds out arm for sleeve, extends leg for pants.

1-2 Years

7. Brings arm to sleeve in dressing.
8. Actively helps in undressing self.
9. Begins pulling down pants.
10. Assists with dressing--helps with pants, shirt, sweater, jacket.
11. Undresses with adult assistance for one-half of clothing.
12. Unzips zipper.

2-4 Years

13. Removes shoes, socks, pants in appropriate sequence.
14. Attempts to put on some clothes independently--may put both legs in 1 pant leg or get shirt on backwards.
15. Pulls on simple garment independently (poncho, apron).
16. Finds sleeve independently when dressing and pushes arm through.
17. Removes coat or dress independently (may need some help with buttons).
18. Puts on shoes and socks (may put shoe on wrong foot)
19. Hangs coat on hook independently.
20. Attempts unbuttoning and buttoning, but doesn't get button through hole.

4-6 Years

21. Unbuttons large buttons.
22. Attempts to lace shoes, usually incorrectly.
23. Dresses with little assistance if clothes are laid out (except for buttoning).
24. Distinguishes front from back of clothing.
25. Dresses self except for back fasteners.
26. Buckles shoes or laces them, but does not tie laces.

27. Button clothing.
28. Dresses self independently except for tying shoe laces.

Project APT, Fairfax, Virginia

SUGGESTED EQUIPMENT LIST FOR SELF-HELP - DRESSING

0-6 Months

Student's own clothes

6 Months-1 Year

Student's own clothes
Hat
Socks
Shirt or sweater
Pants

1-2 Years

Shirt or sweater
Pants
Jacket
Clothing with zipper

2-4 Years

Shoes
Socks
Pants
Shirt
Poncho, apron, or oversized T-shirt
Coat or dress
Coat hook
Clothing with large buttons or button board

4-6 Years

Clothing with large buttons or button board
Shoes with laces
Student's own clothes

Project APT, Fairfax, Virginia

TEACHING ISSUES

REINFORCEMENT--A TEACHING TOOL

Ann Ballentine Carr

Reinforcement is a powerful tool in shaping children's behavior. Reinforcement often influences children, or any of us, to want to do something again. Parents can use reinforcement to increase behavior that they like in their children.

Objectives

1. Parents will be introduced to the concept of reinforcement.

2. Parents will demonstrate knowledge of how to praise.

3. Parents will demonstrate knowledge of what to praise.

4. Parents will demonstrate knowledge of when to praise.

Preparation

1. Make copies of "Reinforcement--How Do I Do It?" handout.

2. Collect materials: blackboard and chalk or newsprint pad and marker, paper and pencils.

Sequence

1. Choose one of the "Ways to Begin" to help parents think about what reinforces them. (5-10 minutes)

2. Use #3 in "Ways to Begin" to help parents think about what is reinforcing to their children. (10-15 minutes)

3. Provide information about what reinforcement is and when it should be used. (10 minutes)

4. Use questions, situations to discuss, and practice activities suggested in "Questions to Continue the Discussion" to demonstrate reinforcement techniques. (15-20 minutes)

5. Discuss the activities to be used at home described in the "Conclusion" and "Next Steps" sections. (10 minutes)

Ways to Begin

1. Ask parents, "What is reinforcing to you?" "What makes you want to do something again?" List their answers on the blackboard or newsprint pad. After several parents have responded, observe that there are individual differences. What is reinforcing to one person may not be reinforcing to another.

2. Compliment a parent in the group. (For example, "I really like the blouse you have on. It's a pretty color.") Then ask the parent how she felt after the compliment. (For example, "Will you wear the blouse more in the future?" "Do you think any differently about the blouse now that I have commented about it?") Encourage discussion by asking parents to think of a situation in which they have been complimented on something that they cooked, wore, or did. Ask them how they felt about the compliment.

3. Ask parents, "What are some of the things that reinforce your children?" What makes them want to do something again?" List their responses on the blackboard or newsprint pad. Point out that children are reinforced by different things, just as adults are. Distribute the "Reinforcement--How Do I Do It" handout. Have parents identify on the handout things that reinforce their children. Invite parents to add other suggestions from the blackboard to the handout sheet.

Information to Consider

One major role that parents play in their children's lives is that of a teacher--teaching their children to behave, giving them information about the world around them, and teaching them to be independent. Parents use many different methods in helping their children learn. Reinforcement is a powerful tool that parents probably already use to shape their children's behavior. By "catching a child being good" and reinforcing the behavior, a parent will probably help a child continue and increase the particular behavior that the parent likes. Reinforcement is a positive child-management technique.

Reinforcement--What Is It?

Reinforcement is anything that increases a behavior or makes a person want to do something again. Reinforcement must be rewarding to the person receiving it. What reinforces one child may differ from what reinforces another child. Observing a child's response is a good way to find out if a reinforcer really is rewarding.

Reinforcement--When Do I Do It?

Reinforcing a desired behavior every time that it happens is called "continuous reinforcement." When children are beginning to learn a skill, continuous reinforcement will probably help them learn more quickly. If children cannot perform the complete skill, parents can reinforce approximations of the desired behavior. For example, a father might clap his hands every time his child picks up her cup and attempts to put it towards her mouth. He would continue to reinforce the approximations until she demonstrated the desired behavior. This process is called shaping.

After children perform a desired behavior most of the time, reinforcing them on an intermittent (or occasional) basis is probably the most effective way to maintain the behavior. This happens naturally in a home setting. For example, a mother might say (in her own words and style), "Nice drinking, LaShonda" at two times during meal time, rather than every time she drinks out of a glass.

Reinforcement--How Do I Do It?

Refer to the handout for ideas and add suggestions from the group.

Questions to Continue Discussion

1. What situations or activities do you especially enjoy with your child? What games or situations does your child especially like? How do you reinforce each other in these situations?

2. Choose one of the following activities for a practice session:

(a) Arrange for a parent to bring his child to the parent group. Demonstrate the reinforcement technique with this child for a short period of time (about 5 minutes). (For example, if the child is learning cup drinking, reinforce her as she approximates the desired end behavior of drinking from a cup.) Ask parents to think about the following questions as they watch the demonstration: what kind of reinforcement(s) is the leader using? When does she use them? What is the child doing after the reinforcement(s)? Discuss the answers to these questions following the demonstration.

(b) Ask two parents to role play the situation described in (a).

3. Ask parents to divide into groups of two. Give each group a situations to be discussed. Ask parents to read the situations and discuss the following questions: "What kind of reinforcement could be used?" "When could it be used?" "How will parents or teachers know if they are using a good reinforcer?" After the small groups have come to a conclusion regarding these questions, have them report the situations and their answers to the group as a whole.

The leader may want to think of situations that are pertinent for the families in the group or even actual examples of situations with their children. (Actual examples provide lively conversation! However,

it is important to stress that reinforcement is only one way of handling situations and to avoid criticizing parents' child-management techniques.)

Situation 1. Gwen has a vision problem. The parent-infant teacher and Gwen's mother want her to learn to have better eye contact. She occasionally looks at her mother when she is holding Gwen's glass of milk. What kind of reinforcement could be used? When could it be used? How will you know if it is a good reinforcer? (Possible answers: Give Gwen her milk immediately after she looks at Mom. Hug Gwen when she looks at her Mom. Gwen will increase her eye contact over a period of time if milk and hugging are good reinforcers.)

Situation 2. Brandon's parents are watching TV. They notice that they have been able to watch a show uninterrupted, while he plays quietly in his room. What kind of reinforcement could be used? When could it be used? How will you know if it is a good reinforcer? (Possible answers: Parents could go in during a commercial and say "I like the way you're playing quietly. We could watch the TV show." The parents will probably notice that they are able to watch TV more often without being interrupted. Brandon may also act pleased when his parents reinforce him.)

Situation 3. Lee Ann is learning to crawl. Her father moves one foot away from her and encourages her to come to him. Lee Ann moves forward a couple of inches and then stops. What kind of reinforcement could be used? When could it be used? How will you know if it is a good reinforcer? (Possible answers: Lee Ann's father could clap his hands when she moves forward even a little. Lee Ann will keep on attempting to crawl, if her father is using a good reinforcer.)

Conclusion

Give each parent a sheet of paper. Ask them to write down one or two examples of behavior that their child does that they like and want to see increased. Ask parents to share their answers with each other. (Sometimes parents think of their children's behavior in global terms; for example, "I like it when Chris is good." Ask the parents, "what does Chris do when he's good?" to help define "being good" in terms of specific behavior. A response might be, "I like it when he drinks out of his cup and doesn't spill." Drinking without spilling is easier to praise than "being good.")

Next Steps

1. Ask parents to choose one behavior from the "Conclusions" exercise to reinforce during the following week. At the next parent meeting, discuss the following questions: "What kind of reinforcement did you use?" "When did you use it?" "What did your child do after the reinforcement?" "How did you know if it was a good reinforcer?" (Parents often feel that this assignment sounds easy to do but they may have difficulty in carrying it out. Mention possible difficulties to parents so that they will not feel that they are failing if they experience problems.

2. When parents are teaching a new skill in the future (for example, reaching for a toy, or crawling), be sure to include a discussion on how reinforcement can be used.

3. If parents indicate an interest, other parent group topics could center on behavior management techniques such as ignoring inappropriate behavior, deciding when to punish, and setting limits. Refer to section "For More Information" for material on these topics.

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Reinforcement--How Do I Do It?

A child is more likely to do something again if the event is followed by some of the following reinforcers. (Adapted from Madsen & Madsen, Parents, Children, Discipline: A Positive Approach, 1970.)

Verbal

Yes!
Good for you!
Great!
How nice!
Good job!
Thank you.
That's right.
I like that.
I like the way you. . .
You did that well.

Facial Expressions

Looking
Smiling
Nodding
Grinning
Whistling
Widening eyes
Wrinkling nose
Forming kiss

Bodily Expressions

Clapping hands
Extending with arms
Bouncing and jumping
Patting with hands
Stroking
Hugging

Nearness

Interacting with child at playtime
Eating next to child
Sitting on bed near child
Lying down with child before bedtime

Touching

Holding
Hugging and rocking
Leaning over
Pinching cheek
Tickling
Kissing
Cupping face in hands
Quick squeeze

Things

Teething ring
Rattle
Stuffed animals
Bath toys
Favorite blanket
Big bright picture book

Food

Bits of fresh fruit
Raisins
Cereals
Juices
Crackers
Teething biscuits
Milk
(small portions of any favorite food)

DISCIPLINING CHILDREN WITH HANDICAPS

Elizabeth F. Gerlock

Disciplining children with disabilities may present special problems. However, as with other children, disciplining, or setting limits, is part of the overall relationship between parents and children that includes caring for, teaching, loving, and playing with children. When children's behavior has become a problem for parents, a systematic approach to identifying and examining the behavior and looking for possible ways to handle the problem may help parents.

Objectives

1. Parents will recognize that their disabled children may present special discipline problems caused by their child's problems, not by their parenting.

2. Parents will have an opportunity to discuss problems that they are having with their handicapped child or with other children in the family.

3. Parents will be able to describe the kinds of interactions between parents and children that help children achieve and develop as fully as possible.

4. Parents will be able to explain the steps in one method of changing problem behavior.

Sequence

1. Use one of the "Ways to Begin" to help parents think about differences and similarities between disciplining their children with handicaps and disciplining other children. (5-10 minutes)

2. Discuss the role of parents in structuring the environment in order to help children grow and learn. (See questions 1 and 2 in "Questions to Continue the Discussion.") (5-10 minutes)

3. Outline three ways that parents handle discipline according to Baumrind (In Tomlinson-Keasey, 1980). Use questions 3, 4, and 5 in "Questions to Continue the Discussion."

4. Ask parents to describe a behavior problem that they have with their children. Ask group members to suggest possible causes of the behavior and possible solutions. (15-20 minutes)

5. Outline a behavioral approach to identifying and handling behavior problems. Illustrate how such an approach might be used with one of the problems described by a parent. (15-20 minutes)

Ways to Begin

1. Ask parents if they believe that their children's disabilities require them to discipline them any differently than other children are disciplined.

2. Ask parents if they feel reluctant to discipline their children because of their handicaps.

3. Ask parents if other people in their families disagree with their handling of their children.

Information to Consider

This section suggests several ways of looking at discipline in order to allow leaders to present different approaches or to choose the approach most appropriate for their groups. Parents' child-rearing techniques should be respected. Suggestions of ways of handling discipline problems will be more likely to be implemented if they conform to parents' beliefs about child-rearing and with their style of interacting with their children.

Disciplining Children with Impairments

Parents differ markedly in their handling of special children. Some strive to integrate their child into the family completely, making the same demands of and placing the same restrictions on the special child as they do their other children. Usually it is necessary to make some allowances for differences (as it is with other children). Other families may feel sympathy for their child because his life is difficult and painful and thus may make fewer demands of him than they would if he had no problem (Buscaglia, 1975). Some parents become overly attentive to their child, devoting all their energies to her and keeping her at an infantile level. Too much sympathy and attention prevent children from learning important self-help skills and from exhibiting behavior that will make them acceptable to others. Sometimes children with serious handicaps who have very little means of self-expression will passively resist learning self-help skills or will refuse to do things that they previously had shown they were able to do as a means of asserting themselves as individuals and as a way of manipulating their environment. Other children scream to get attention and gain social stimulation (Finnie, 1974). Parents need to look for ways that children can express themselves positively, while at the same time insisting that their children continue to learn and to perform self-help skills as best they can. Parents need to respond to children's signals in order to prevent children from having to scream or be destructive in order to attract attention.

Children with handicaps often encounter frustrating situations because of their problems. Difficult situations such as not being able to

control motor functions to solve problems or being left out of group activities may produce "acting out" behavior in children. Children with limited intelligence fail to pick up cues from other people about how they should behave. They may have trouble understanding or remembering restrictions. Periods of exploration (the "terrible two's") may occur later, and may last longer than in other children. Children who are blind or deaf miss many cues such as smiles, frowns, tones of voice, and the behavior of others that help structure behavior. Children with brain damage may have trouble sitting still, controlling their movements or their emotions, and relating to other people.

During the first part of the discussion period, parents can be helped to recognize special difficulties that their children's disabilities may cause in disciplining them. A realistic appraisal can help relieve parents of guilt that they may feel regarding their children's behavior. Making practical suggestions as well as establishing an attitude that the children are capable of learning appropriate behavior can help parents expect their children to develop socially and to learn age-appropriate skills. Finnie (1974) states that when a child seems not to develop, parents also may not develop in their expectations for their child. However, leaders need to be careful not to condemn parents' handling of their children's behavior in order to avoid creating more guilt feelings than parents may already have.

Parents' Role in Structuring Children's Environments

Regardless of the impairment, a child is a child first and a child with a handicap second (Buscaglia, 1978). In a study of competent children, Burton White (1979) detailed three main functions of effective child-rearers:

1. Designing a child's environment so that it is safe and includes maximum opportunities for learning and exploring and materials to prevent boredom.

2. Acting as consultants, offering needed comfort or assistance as well as being available when childern have an exciting discovery or need help with a frustrating problem. Parents can use both moments of discovery and moments of frustration as opportunities for teaching. They can identify what children are interested in and then expand on that interest. They can provide some assistance so that children can solve a perplexing problem before they give up.

3. Setting limits or disciplining children. Discipline is part of a total relationship and the total environment established by the family. When a relationship is positive, children probably will want to please parents. When parents are understanding and sympathetic towards children's needs, a trusting, nurturing environment is established. When parents are confident in their abilities to care for their children, to be firm and decisive when firmness is needed, discipline is often less of a problem even with a difficult child. Brazelton (1978, p.122) states that discipline "must be part of an adult's total commitment to the child, not just a reaction to the immediate provoking behavior." Knox (1978) states that

children's misbehavior is often a reaction to hurt feelings, frustrations, and anger, which children feel just as adults do. Adults can model ways of handling their own feelings, acknowledge children's feelings ("I know you are angry because Johnny took your car."), and provide alternate solutions to the problem. ("Would you like to share your cars with Johnny or get him something else to play with?") Children should be treated with the same respect that we expect from them and with the same respect with which we treat other people (Knox, 1978).

Baumrind has defined three kinds of strategies that parents use with their children (Tomlinson-Keasey, 1980).

1. Authoritarian. These parents demand obediance when their children are negative and reject feelings as a motive for behavior. These children learn to be compliant and submissive, suppressing some of their capabilities for a range of feelings, decision making, and initiative.

2. Authoritative. These parents establish clear, consistent rules setting standards of acceptable behavior for their home. However, they listen to what their children want, and many decisions are made by children and parents together. Authoritative parents explain why decisions are made and accept children's feelings even when their behavior is not acceptable. Children learn that sometimes their wishes are met, and other times they are not.

3. Permissive. These parents accept all feelings and behavior and set no limits. The children are not well prepared to cope with the structure that they encounter in school and in life.

While a system of classifying all parents into three categories seems simplistic, the group may find these categories useful in discussing how authoritative parents, as described by Baumrind (1980), and parents who arrange the environment, consult, and set limits, as described by White (1979), will help children with disabilities as well as other children learn behavior that is acceptable. The role of parents may be especially significant with handicapped children since some of these children have more difficulty learning appropriate behavior.

Disciplining Techniques

White (1979) stated that children less than 1 year old can usually be controlled by distraction; children from on to 1 to 1½ years of age require distraction and physical removal from circumstances or removal of the object. Children from 18 months on require distraction, physical distance, and firm verbal restriction with eye contact.

Children who have good receptive language and a good relationship with their caregivers often react surprisingly well to cognitive control. Parents or teachers let children know that they can control their own behavior. In a preschool classroom, one little girl often cried far more than the injury either to self or pride warranted. On different occasions, teachers tried comforting her, and they tried ignoring the crying, but the lengthy crying continued. Finally, one teacher asked her if she would

like to stop crying. Through her tears the little girl nodded, "Yes." "Well then, you can stop," the teacher told her. With that the child stifled her sobs, took a few deep breaths, and resumed normal activities. This approach continued to work with her, gradually eliminating the extensive crying. Children, even very young ones, can be given choices and can learn to feel that they are responsible for their own behavior.

Behavior Management Techniques

Baker, Brightman, Heifetz, and Murphy (1977) explain helpful techniques for managing behavior problems from a behavioral point of view. They describe the following steps:

1. Identify the behavior causing the problem. Problems may include behaviors that interferes with learning such as a child's screaming or dropping materials during a teaching session; behavior that interfers with skills already learned, such as a child's refusal to feed himself or dress himself when he can; and behavior that is disruptive to the family or harmful to the child, such as getting up and running around at mealtime, or self-abuse behavior.

2. Examine the behavior. Pinpoint the behavior that needs changing rather than using general descriptions, such as, "Billy is wild." Count how many times the child does the targeted problem behavior during a specified time. Behavior that occurs infrequently may be counted all day; behavior that occurs often or more than once in 15 minutes may be counted during a shorter period. After a program has been initiated, again count the number of times that the behavior occurs to determine how much improvement is being made.

Look at what happens before the problem behavior occurs and what happens after the behavior has occurred. For example, at mealtimes the family talked and paid little attention to Gary. He got up and ran around. They then chased him and brought him back to his seat. The family's lack of attention to Gary was the antecedent of his running around. The family chasing him was the consequence and gave him the attention he wanted. Parents often reward problem behavior by giving attention, by providing an activity that the child enjoys (just to get him to shut up), or by permitting the child to escape a situation he does not enjoy.

3. Initiate a program. Changing the antecendents and consequences can help change the behavior. In the example given above, paying more attention to Gary at the table and ignoring him when he ran around helped to increase his staying at the table. After deciding on a program, parents should once more count to determine how well it is working.

Whatever method is chosen for handling misbehavior, a sense of caring must accompany discipline in order for it to be effective in helping a child learn inner controls. Without caring, "discipline remains just punishment." (Brazelton, 1978, p.123)

Questions to Continue the Discussion

1. Ask parents how they think that they can help prevent behavior problems from occurring. Describe White's (1979) role of the parent in designing the child's environment.

2. Ask parents to describe their relationship with their child. Ask them what kinds of things (such as food, comfort, information) their child seeks them out to obtain. Describe White's (1979) role of a parent as the child's consultant.

3. Ask parents how they set limits on their child's behavior.

4. Describe the authoritarian, authoritative, and permissive parent. Ask parents which approach they generally use and an example of the way they handle their child.

5. Ask parents to consider what effects permissive parents might have on a child with handicaps; an authoritative parent; an authoritarian parent.

6. Ask if anyone's child has a particular behavior problem that is bothering them. Ask when the problem occurs, how often, and what methods the parents have tried to handle the problem.

7. Ask for suggestions from group members about handling a problem described. Describe the behavioral approach to handling problems, or plan to have a separate session to present the behavioral approach and how to use it with a specific problem that a child in the group has.

8. Ask parents what their long-range and short-term goals are for their child in regard to behavior in social situations in and outside the home.

Conclusions

Parents sometimes feel that they are walking a tightrope in their efforts to limit behavior while promoting independence, and to stop objectionable behavior while encouraging a positive self-concept. Parents need to receive positive reinforcement for the very difficult job that they are doing. They do not need to feel "put down" when their discipline methods differ from a leader's or other group members' approaches. There is no one right method for handling behavior. Families and children are all different.

Next Steps

The group may want to plan several sessions on behavior problems. They may want to precede or follow this module on discipline with the module "Reinforcement--A Tool for Learning."

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PLAY

Elizabeth F. Gerlock

Through play, parents and children learn to respond to signals from each other and to deepen their relationships. Children develop a sense of competency by initiating their own play activities, and through play they learn about the world around them. Children with handicaps may need help to learn to play because they may be less responsive, less imaginative, and less resourceful in their play than other children.

Objectives

1. Parents will discuss ways to enhance their interactions with their handicapped children.

2. Parents will discover ways to encourage their handicapped children to initiate interactions and play.

3. Parents will receive examples of ways to respond to and elaborate on the play that their children begin.

4. Parents will choose toys that are appropriate for their children.

Sequence

1. Use one or more of the "Ways to Begin" to help the group think about play. (10-15 minutes)

2. Present some of the ideas about play from the "Information to Consider" section. Allow time for parents to react to ideas presented and to give examples of play activities that their children do. (20-30 minutes)

3. Use suggestions from "Questions to Continue the Discussion" to develop ideas of ways that parents in the group can play with their children. (15-20 minutes)

4. Summarize the main ideas that group members have discussed. (5 minutes)

Ways to Begin

1. Ask parents what their children like to play with.

2. Ask parents how their children play with objects and toys.

3. Ask parents if their children are able to play for short periods by themselves if they are given a few interesting toys or objects.

4. Ask parents to describe any differences in their children's play when an adult or older child plays with them.

Be alert to any indications that parents may be having difficulties understanding the importantance of play, providing play materials and play space, or being attuned to their children's interests and tempo in play. (Bromwich, 1981).

Information to Consider

Beginning of Play

Play activities between parents and their handicapped children may be slow to develop because mothers and fathers may be overwhelmed with the difficulties of caring for their children, especially if they have serious medical difficulties. These children may also be slow to respond and may have trouble coping with their feelings of disappointment with their child. However, most parents and infants soon begin to initiate interactions and to respond to each others' smiles, voices, and movements. One mother of a young child with multiple handicaps that included blindness noticed one day that when she pressed her daughter's hand, her daughter squeezed back. This same little girl, who responded very little to any other stimuli, showed her pleasure in hearing her mother sing a familiar song through her facial expressions and vocalizations. This mother and child, through play, had found a way to enjoy mutually satisfying social interactions.

Brian and Shirley Sutton-Smith (1974) state that parental care, cuddling, and rocking of infants, precede development of a pattern of mutual responding. Parents talk to their baby and gaze into the baby's eyes to focus attention. Bouncing, singing, exaggerated social expressions, and a variety of sounds follow as parents seek to keep their baby's attention. Babies also seek to capture their parents' attention by smiling, gurgling, and wiggling. When there are sensory deficits, parents must rely on the intact senses to elicit responses from their child. The parents of a three year-old deaf-blind child discovered that she liked to be swung in the air. She would back up to them indicating that she wanted them to lift her up again. Not only were her parents learning through play to respond to her signals, but also she was learning to communicate; and together parents and child were laying the foundation for language. The main focus of the interaction, however, was having fun with each other. The adult enjoyed making the child laugh, and the child enjoyed the excitement of being tossed in the air. It also gave her a sense of competence to be able to

indicate that she wanted to be tossed in the air and to have her wants understood.

Elements of Play

Sometimes parents of handicapped children are so dedicated to providing early intervention for their child that they spend all their spare time teaching their child. How is play different from teaching and caring for a child?

Play takes place in a relaxed atmosphere where there are no undue restrictions. The goal is to have fun, "to get in touch with each other" (Sutton-Smith, 1976), to enjoy each other. Play gives children freedom to experiment and make mistakes, to practice over and over skills that they have learned. Piaget (1962) observed that children who had learned to produce an action, such as shaking objects while they held them, later laughed when they performed the same action--this showing their pleasure in producing an action that they had learned to do well. In play there are no failures of evaluations. Sometimes children perform more difficult skills in the relaxed atmosphere to play than they do in a structured teaching situations (Chance, 1979). Adults playing with children who are very destructive or self-stimulatory will need to make greater efforts to guide children's play, to gain more eye contact, and to encourage normal play activities when they occur (Bromwich, 1981). Play may not be as rewarding for parents with a very difficult child as it is for parents with a very responsive child, but parents can become sensitive to small gains that their child makes.

Play gives children an opportunity to influence their environment. A child with severe handicaps hits her musical ferris wheel and causes it to begin moving and playing again. Another child discovers cause and effect by touching the moving feet on a wind-up toy, stopping them, then lifting his finger to allow them to move again. However, a child playing alone, especially a handicapped child, may think of a limited number of actions in interacting with toys. Chance (1979) states that children learn to play most effectively when adults play with them. Adults can follow the lead of the child and then elaborate on what the child does. If a child bangs on his highchair tray with a spoon, his mother bangs on the tray and taps the cup to make two sounds instead of one. If a child pushes a toy car, the father pushes the car and parks it in a make-believe garage. In Learning Through Play, Lewis states that adult response to children's actions is crucial to children developing a feeling of competency and to understanding that their actions produce consequences (Chance, 1979).

Social Development in Play

Young children saying "mama" after their mothers say "mama" or hiding their eyes after their fathers hide their eyes are learning to imitate and to take turns. Children engaged in pretend play are learning the social rules that govern certain situations and are learning how other people feel (Chance, 1979). However, children with handicaps may

be less imaginative in their play. Warren (1977) reports that Singer and Streiner found that the imaginative content of the fantasy play of blind children that they studied was significantly lower than that of sighted children. By playing with their children, parents can help children learn to play more imaginatively (Chance, 1979) and also can help the children with handicaps learn to play with other children, including sisters or brothers. Adults can serve as models both to show handicapped children how to play and to show other children ways to involve handicapped children in play, including ways to treat unusual behavior.

Children with handicapping conditions differ widely in their ability to learn to play with other children. Satisfactory relationships depend on other children's tolerance of differences in appearance and behavior and on a handicapped child's ability to develop play skills and adaptive social behavior. Menolascino (1978) considers mentally retarded children "at risk" for development of emotional disorders. He states that their ability to meet environmental demands and expectations and to make a satisfactory emotional adjustment depends on being surrounded by supportive adults.

Choice of Toys

Summarizing a 1977 Pediatric Round Table discussion on play, Chance (1979) made the following observations on choices of toys.

1. Children, even infants, prefer unfamiliar, novel toys. Novelty can be produced by mixing unrelated toys, doing different things with the same toys, modifying toys, and by using household materials such as cans, boxes, bags, and old clothes.

2. The best toys encourage a child's participation, such as trucks to roll, mobiles to hit, or xylophones to play. Playing with such toys gives children a sense of competency because they cause something to happen.

3. The best toys are simple ones that can be used in a variety of ways, such as rattles, blocks, dolls, and riding toys.

4. People are the most functionally complex playthings.

5. Young children need realistic toys, but as they get older they learn to enjoy less structured toys and are able to pretend with toys. (For example, a block can be a gun, a baby, a wall, or a car.)

Taking time to observe what children do with objects and toys can help parents discover how their children explore objects, what skills their children have acquired in playing with objects, how they react to new objects, and how some objects and toys encourage them to use more advanced skills (Bromwich, 1981).

When Not To Play

Children need time to play alone, to practice skills, and to make problem-solving discoveries by themselves. Sometimes children may be engrossed in their play and an adult entering their world would be an intrusion. Play should continue only as long as it is fun for both child and adult (Chance, 1979). By forcing themselves to play when they are tired and would rather be resting or doing something else, parents may create an atmosphere that is more damaging than helpful to their child. In addition, play with young children should be discontinued when they become tired or bored.

Questions to Continue the Discussion

Choose questions to learn more about how children in the group play and to help solve difficulties that parents may be having.

1. Ask about children's playing style. Some children go after toys right away, while others have to be encouraged to play with them. Some children play with toys for a long time and some have short attention spans. Some children play alone, while others wait for someone to play with.

a. Ask parents if their children like to explore objects or if they need to be encouraged to play.

b. Ask parents if their children play with a toy for a few seconds and then go on to the next toy or if they play with a toy that they like for longer periods. Ask if the particular toy makes a difference in how long their child plays.

c. Ask parents if their children are able to play alone when given a few toys that they like.

If parents seem to have a problem with their child's play, ask if anyone else in the group has had that problem. Ask what they did about it.

2. Explore with parents ways that they can respond to what their child does in play.

a. Ask parents how their child lets them know what he or she likes;

b. Ask parents what they believe their child enjoys doing with them;

c. Ask parents to think of an example of a way that they elaborated on their child's play.

3. Ask parents for examples of things that they have observed their child learning through play.

4. Ask parents for examples of ways that they can help their child to learn more through play.

5. Ask parents whether they have difficulty finding time to play with their child. Encourage parents to tell about their favorite time to play with their child.

6. Ask parents whether their children are easily distracted from play by normal family activities around them. Help parents recognize that by reducing distractions, their child may be more able to concentrate and to learn from play (Bromwich, 1981).

7. Ask parents how their children respond to playing with brothers and sisters and family members.

8. Share ideas about toys that children in the group like and other toys that they might enjoy. Having parents look through toy catalogs may help to encourage a discussion of appropriate toys.

Conclusion

Play is a time for parents to enjoy their children, to respond sensitively to them, and to help them learn. Recall with the group examples that they have generated of ways they play with their children. Play is also a time when children can initiate their own activities, thereby developing a sense of competency. Parents can help by elaborating on what their child does when they play together in a relaxed atmosphere.

Next Steps

If group members are interested, plan a session to make play dough and other homemade toys such as shakers from pot-pie containers, drums from oatmeal boxes, and other easy-to-make toys.

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John F. Kennedy Center for Research
Box 40, Peabody College
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Nashville, Tennessee 37203

Receipe for Play Dough

2 cups flour
1 cup salt
2 tablespoons cooking oil
2 teaspoons cream of tartar
2 cups water
food coloring

Mix ingredients in a saucepan and cook over medium heat. Stir constantly with a big spoon. When the mixture gets too heavy to move around, turn it out onto a flat surface and begin to knead as soon as the dough is cool enough to touch. Wrap it thoroughly in plastic and keep it in the refrigerator.

THE RULES OF TALKING

Ann Ballentine Carr

The first few years of children's lives are a critical time for learning language. During this time parents' use of language serves as an important model for their children. Parents can optimize their children's language learning by using techniques such as reinforcement, repetition, modeling, and corrective feedback.

Objectives

1. Parents will be provided with information about techniques used to facilitate language learning.

2. The group leader will demonstrate several language teaching techniques.

3. Parents will practice several of the techniques through role playing.

Preparation

1. If possible, order the following materials from Intersect, 1101 17th Avenue South, Nashville, Tennessee, 37212 (Telephone: 615-327-2948): Pay Attention When You're Talking. (½" videotape cassette, $42) Rules of Talking booklets ($2.50 each)

2. Secure materials needed for the session: video playback unit, TV monitor, (if videotape is to be used) paper, pencils.

Sequence

1. Use one or two of the 'Ways to Begin' to help parents think about their role in assisting their children learn to talk. (10 minutes)

2. If available, show the Pay Attention When You're Talking videotape. Ask parents to keep in mind the following question while they watch the videotape: "Which is the one rule that you consider most important when communicating with your child?" (15 minutes)

3. Discuss parents' reactions to the videotape, as well as the communication rules that they choose as being important. (10 minutes)

4. Discuss the Rules of Talking booklet. Demonstrate several of the rules by engaging in one or two role plays. (Ask parents to role play their

children. See "Questions to Continue Discussion" for role play suggestions.) (20 minutes)

5. Conclusions and next steps. (5 minutes)

Ways to Begin

1. Distribute the Rules of Talking booklets. (Ordering information is located in 'Preparation' section.) Give parents time to read the booklets and to make comments.

2. Just before the parent group session begins, stand on a chair. Begin the parent group by saying that the discussion will center around the "Rules of Talking," which facilitate children's language learning. Discuss the card "Creating a Climate for Communication." Step down off the chair as you talk about the rule "Get down on your child's level." (This act will draw attention and discussion! It will also dramatize for parents the intent of the rule.) Ask parents to share their feelings about the "standing on the chair" experience. (For example, "How did you feel when I was so much taller than you were?" "Did you feel I was trying to communicate more when I was on your level?" "Why?" or "Why not?")

3. Ask parents to write on paper the level of their child's language. (For example, "My child says sounds such as 'ah,' 'ee.'" "My child says two-word sentences such as 'mama,' 'shoe.'")

Information to Consider

The "Rules of Talking" were developed by staff members of the Mama Lere Parent Teaching Home at the Bill Wilkerson Hearing and Speech Center (Vanderbilt University, Nashville, Tennessee). These rules provide parents with guidelines for talking with their children in a way that will optimize their language learning. The guidelines focus on how to reinforce what their children say, how to talk about what is relevant to their children, and how to use techniques such as repetition, modeling, and corrective feedback. These rules were developed originally for use by parents of hearing-impaired children and were used later with parents of language-impaired and developmentally-delayed children (Horton, 1974). A brief summary of the "Rules of Talking" follows.

Creating a Climate for Communication

Children learn to talk more quickly when they are in an environment that facilitates language learning than where they are not. Such an environment is created when a parent tunes into a child's interests. Young children's interests can be found by observing their eyes, ears, hands, and feet ("Where is he looking?" "What is she doing?" "What is he listening to?" "Where is she going to play?"). Language is learned when children hear language that describes the activities in which they are actively engaged; for example, a child learns the word "milk" during mealtime more readily than in other situations. Children are reinforced for listening to talking when parents smile and engage them in activities that

they like. All these techniques give a child a reason to talk.

Listening for Children's Messages

Although handicapped children's attempts to talk may not always be intelligible, reinforcement of these attempts will make communication a pleasurable experience and will motivate a child to continue efforts to communicate. Children are reinforced when parents are interested in what they are saying. They are also reinforced when what they say produces changes in their environment. (For example, when a child approximates the work "milk," his father gives him some milk. The child thus learns that he can get something that he wants when he says the word "milk.")

If a child's words are difficult to understand, listening to the tone of voice may help parents infer the message. A child's face, body, and hands may give additional clues to what the child is attempting to communicate.

Making Your Talking Relevant

Since children learn language from hearing it, is is important for parents to describe and give words to children who do not yet have the words for specific events. Children learn words when parents talk about what their children are doing, hearing, seeing, smelling, or tasting. (For example, a parent might say "I'm picking you up in the air" when picking a child up.) It is equally important to give children words for their feelings. (For example, "You're angry.")

Encouraging Children to Use Voice to Make Sounds

Children's cooing and babbling are essential first steps in the talking process. During this time, children practice making sounds that will later be used in words and sentences. Some children with handicaps do not often coo and babble, thus lacking valuable practice of speech sounds. Parents can encourage children to make sounds to the best of their ability.

Games (such as "Pat-a-cake" and "Rooster, hen, pullet") and simple songs (such as the "Bumble Bee Song") give children necessary opportunities to vocalize sounds. Adding voiced sounds to accompany a child's repeated movements also facilitates vocalization. (For example, a parent makes a "mm" sounds while moving a car back and forth over a table.) Children's vocalization tend to increase when the sound that they make are imitated. (For example, child says "mamama," then parents say "mamama.") Children can learn new sounds by hearing them with their own sounds. (For example, child says, "mamama," then parents say "mamadada.")

Helping Children Understand Words

Parents can help children to understand words by naming objects and by naming their children's actions. (For example, a parent may say "You're

eating your sandwich. See the apple; the apple is on the plate.") Naming can be done during daily routines, such as bath time and meal time. Since children learn to understand names of objects only after hearing them many times, repetition is an important tool in teaching children to understand words.

Parents should first tell and then show children what they want them to do. Children hear the words describing what they are about to do and are given a chance to demonstrate their understanding of these words. (For example, "Take off your pants. That's right. You're taking off your pants.")

Talking When Children Begin to Use Words

After children have learned to understand words, they begin to use words. Parental attention as well as parental action are effective rewards when a child attempts to say a word. (For example, a child says, "milk." Parent says,"You want milk. Here's your milk.")

A child learns to expand words into sentences by hearing parents elaborate on what he or she said in the following ways:

1. When a child uses single words to communicate, a parent can repeat the word and use it in a sentence. By doing this, parents demonstrate ways of expressing thought in sentences and also reward their child for using a word. (For example, child says,"shoe," and parent says,"Oh look, the shoe fell off.")

2. When a child uses incomplete or incorrect sentences, parents should repeat the message correctly without commenting on the error. Modeling correct language is a powerful tool in producing change in a child's use of language without need for calling attention to errors. (For example, child says,"fall down," and parent says, "Oh look, the shoe fell off the table.")

3. A child's knowledge of language is increased when a parent repeats their child's sentence and then expands the thought by adding new information. (For example, child says,"Birdie flied away," and parent says, "Yes. The bird flew away. The bird flew away with his wings.")

Questions to Continue Discussion

1. Ask parents to choose a routine that they repeat frequently with their child (for example, bathing). Ask them to think of words that they can teach their child during this time. (For example, body parts can be taught during bath time.)

2. Role play suggestions:

(a) Rule to demonstrate: "Everything has a name. Use the name."

Role play: Making a bed. Have a parent pretend to be a

child who wants to help her mother make a bed. The group leader role-plays the parent. The group leader gives directions throughout the entire role-play, substituting the word "it" and other demonstrative pronouns (such as this, that) for as many nouns as possible. (For example, "Give me it. Now put it on this and grab that thing on the floor.")

Questions to ask: "Could you follow my directions?" "Did you have a chance to learn the name of objects, such as pillow and blanket?" "How could I have talked differently during the bedmaking time?"

(b) Rule to demonstrate: "Use repetition. Say it again and again."

Role play: Teaching a foreign word. Choose an object that is located in the room (for example, "la fenetre"--window). Teach the word to parents by repeating the word, pointing to the object, describing the object. (For example, "La fenetre est ferme."--The window is closed. "Il est la fenetre."--It is a window. "Voila, la fenetre."--There is the window.)

Questions to ask: "What is the name of this?" (pointing to the window). If no one can remember, then check to see if someone has a receptive understanding of it. ("Is this called "la porte" or "la fenetre"?) "Was repeating the name a help to you in learning the word?"

(c) Rule to demonstrate: "Listen to the tone of your child's voice. Voices reflect feelings."

Role play: Dejected child. The group leader role-plays a dejected child who is asking for something. Parents should not be able to understand what the child is saying.

Questions to ask: "What do you know about this child even though you can't understand him?" "How do you know that?"

(d) Rule to demonstrate: "Talk about the obvious--what your child is doing, hearing, seeing, smelling or tasting."

Role play: Making a peanut butter sandwich. Choose a parent to role-play a child sitting at the kitchen table with her mother (played by the group leader). The "mother" should talk to her child about what is happening while she is making the peanut butter sandwich. (For example, "Let's open the jar. Oh look, what do you see? Peanut butter. Let's smell the peanut butter. . . .")

Questions to ask: What vocabulary words did the child learn while the peanut butter sandwich was made?

Conclusion

The "Rules of Talking" provide guidelines for teaching language to children in everyday situations, such as meal time and bath time. These guidelines include techniques such as reinforcement of vocalization, repetition of correct sentences, modeling appropriate language, and corrective feedback of incorrect sentences.

Group leaders who chose to begin the session with #3 of "Ways to Begin" (asking parents to write down the level of their child's language) could ask parents to write a "rule of talking" that would apply to their children. The leader could discuss the appropriateness of the rule that they chose.

Next Steps

1. Include books in the parent library that discuss language development techniques. A list of references for parents is included in the "For More Information" section.

2. The "Rules of Talking" can be demonstrated during snack time. The demonstration can be done immediately following the parent discussion group or at a later time. (Parents often enjoy demonstration immediately after they have been introduced to the "rules of talking.") Assemble the children and parents around the table for snack time. During snack period, demonstrate several language teaching techniques and tell parents which rules you have followed immediately after demonstrating them; or have parents identify the rules that you are following during snack time. Snack time activities to choose from include making Kool-aid, spreading peanut butter on crackers, or simply drinking juice and eating crackers. Parents respond favorably to this activity since they are able to see the rules of teaching language put in action with their children in an actual situation.

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FAMILY ISSUES

FAMILY ISSUES

Family discussion groups and discussion group leaders vary considerably in the amount of time they want to devote to discussing the feelings that parents have when they learn their child has a disability and the effect of that child on their family. Parents' and families' emotional responses will usually surface regardless of the topic being discussed.

The following modules present family issues and parents' and families' responses in three sessions:

Initial Reactions: How Could This Happen to Us?

Family Members: Assisting the Child

Family Members: Assisting the Parent

The module "Parent Needs" includes some of the same concerns as the three modules listed above and some concerns in working with professionals. "Parent Needs" may be presented as an overview with more detailed discussion planned for later, or the group may prefer to use three separate sessions to focus on each issue.

The ideas presented in "Brothers and Sisters of Children with Handicaps" are not repeated in any other modules.

PARENT NEEDS

Elizabeth F. Gerlock

Parents vary tremendously in their ability to adjust to the birth of children with handicaps. Extended families and professionals also vary in their abilities to provide support, information, and assistance to the families of children with handicaps. By having parents identify their needs as well as available resources, additional areas in which support is needed and possible ways of getting that support may be discovered.

Objectives

1. Parents will share their individual experiences and feelings they had when they learned that they had a child with a disability.

2. Group members will identify ways in which nuclear family members, extended family members, professionals, and friends have been helpful or have made adjustment more difficult.

3. Group members will share ideas about how to secure the help that they need.

4. Group members will suggest ways of dealing with people who have not been helpful.

5. Group members will share ideas about ways to identify and meet their own personal needs.

Sequence

1. Introduce the topic and define the scope of the discussion and the objectives. (3-5 minutes)

2. Use one of the questions in the "Ways to Begin" section to start the discussion. (5-10 minutes)

3. Hold a discussion in which the leader summarizes when necessary, reflects feelings that parents have experienced, and uses questions from "Questions to Continue the Discussion" and statements to guide the discussion toward the stated objectives. (40-50 minutes)

4. Summarize the discussion and conclusions of the group. (5 minutes)

Ways to Begin

1. Ask parents whether doctors, educators, therapists, and other professionals with whom they have had contact have been helpful. Ask whether there was information that they would have liked to have been given that was not given. Ask whether there are ways that they would have liked to have received help but did not.

2. Ask parents to give examples of ways that family members and friends have been supportive since they discovered that their children were disabled.

3. Ask group members whether they have problems in finding enough time for themselves; for their husbands or wives; for their other children.

4. Ask parents how they go about securing help and information when they want it. Ask whether they get what they want. Ask why or why not.

Information to Consider

Discovering a Child Has a Handicap

In spite of fears that may haunt families during pregnancy, no one really expects to have a child who is less than perfect. No one expects that an accident or illness will damage their child. Such an event is a shattering experience that some parents may want to tell and retell for catharis and healing. Group members who have not shared with the rest of the group the story of their children's disabilities may be given an opportunity to do so in this session. Other families who have had similar experiences and understand the trauma can listen and be supportive. The leader may choose to help parents identify emotions that they felt during this period and help them reflect on their perceptions of the support that they received from family, professionals, and friends.

Experiences with Professionals

Some parents complain that they have difficulty getting the information that they need from doctors (Buscaglia, 1975). They report that they wanted medical details, technical information, information about problems to look for and what to expect in the near future as soon as they were told about their children's problems. These parents may continue to have questions during the first days after learning about the disability but hesitate to bother the doctor. They may want to know where to get books and pamphlets concerning the condition and how their child can be helped. Parents may feel that they need to gain an understanding of the disability not only to answer their own questions, but also to answer the questions of family members and friends. The group leader may want to provide books and pamphlets as well as names and addresses of organizations that provide information about various disabilities. (See Community Resources Services Module for list.) Parents also may want information about programs that will help their children.

If some parents have had unsatisfactory experiences with professionals, group members can discuss ways to help parents obtain more satisfactory results from their contacts with doctors, therapists, and teachers. Suggestions might include:

1. Make a list of questions to ask prior to meeting the professional.

2. Ask for additional appointments to clarify information.

3. Take notes in order to remember what was said.

4. Keep a file or records, evaluations, reports, and agency contacts for easy referral.

5. Share names of persons in the community who have been helpful.

How Family and Friends Can Help

Periods of crisis may come frequently for families with handicapped children. A child may be frequently hospitalized, a child's slow progress may be discouraging, and the financial and emotional drain on the primary caregivers may be tremendous. Group members might discuss how their family and friends respond to crises and whether the help and support that they have received in the past was adequate and appropriate. Sometimes people may want to help but hesitate to interfere or are not sure what to do. Parents may need encouragement to ask for help from others and to tell people when they would rather be alone.

Parents report being disappointed when grandparents or other relatives are unrealistic in their expectations for the child. It is not helpful to have relatives say, "She's going to be all right," or "He'll get over it" when the facts indicate otherwise. Perhaps parents can improve their rapport with family members in such situations by sharing their own goals for their child. Some parents also have difficulty dealing with pity and comments such as "Poor little thing." Sometimes family and friends blame a mother or father for something having gone wrong. Buscaglia (1975) tells about a mother-in-law who felt that her grandchild's disability had been caused by her daughter-in-law's attendance at parties during pregnancy. Concerned relatives and friends need to have accurate information so that they can have a better understanding of the problem and what realistically can be done about it.

Many parents need babysitters to give them a break from the constant care of their disabled children. Sometimes parents are reluctant to trust anyone else to care for their children, particularly when their needs are difficult to meet. Some parents want a babysitter trained to work with their child or to care for their children in the same way that they do. Sometimes parents cannot find anyone else willing to care for a very difficult child. Group members may want to explore child care resources in the community, including respite care.

How the Immediate Family Can Help

Partners in a marriage need extra support and tangible assistance from each other in sharing the burden of the emotional upheaval brought on by having a disabled child and by the physical care required. At the same time parents need time to relate to each other as husband and wife, as man and woman, as people (Knox, 1978). When a marriage relationship is already troubled, a child with a handicap may add an intolerable strain. In such a situation both husband and wife may focus on their child, blaming each other for the impairment or using their child as an excuse to retreat further from each other. The mother may absorb herself completely in the care of her child and the father may retreat into himself, his work, or into extramarital relationships (Buscaglia, 1975).

The group discussion can provide reinforcement for parents who are supporting each other and continuing to build their relationship by finding time to be together. At the same time, other families can be helped to see their children with impairments as a part, not the focus, of the total family in which the well-being of each individual and of the marriage relationship is crucial (Buscaglia, 1975). Discussing each family members' needs may help. At times the needs of one person in the family may necessitate sacrifices and understanding from others. For example, when a child is in the hospital or one person's job becomes especially demanding, the person involved may need more attention or support than is usually required. However, these needs should be balanced so that no one feels neglected.

Time for Parents

Finally, parents need time for themselves--time to be alone, time to relax, time for recreation, and time to develop special interests. Certainly, early intervention is important, but parents also should be able to plan time for themselves without feeling guilty. Laura Knox (1978) suggests that parents who constantly sacrifice for their children place a tremendous burden on their children, expecting them to fulfill their lives. Parents are more likely to resent their children with handicaps if their lives have been devoted solely to their care. Parents will soon have little to offer to others if they neglect themselves.

Questions to Continue the Discussion

As the discussion progresses, questions should be formulated to explore various problems and to draw other members into the discussion. For example, ask, "Has anyone had a similar experience?" or "Can anyone suggest a way to handle the situation?"

1. Ask group members how they felt when they learned that something was wrong with their child (or grandchild or niece, etc.). Ask how their husbands or wives reacted; how other family members reacted.

2. Ask parents whether they have been able to find competent babysitters as they needed them. Ask about experiences other group members have had with babysitters.

3. Ask if parents' schedules have changed drastically since the birth of their handicapped child. Ask if there are things that parents would like to do but do not have time to do, such as pursuing hobbies or visiting friends.

4. Ask if parents are receiving the emotional support they need.

5. Ask whether husbands and wives find time to be together when the focus of their attention is being with each other rather than being with their child.

Conclusion

Summarize what has been discussed in the group. Include both problems that individuals need to work on and positive steps forward that individuals have made.

Next Steps

More than one session may be needed to discuss all the areas of "Parent Needs." Additional sessions may be devoted to the following: Working with Professionals, the Extended Family and the Disabled Child (see module), and Parents' Needs As Husband and Wife and As Individuals.

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INITIAL REACTIONS: HOW COULD THIS HAPPEN TO US?

M. Diane Smith

Parents-to-be and other family members hope and expect that the child to be born will be healthy and perfect. When a child with a handicap is born, this expectation is violated and parents are thrown off balance, their values and expectations at odds with reality. Thus, they find themselves at the beginning of a road to readjustment.

Objectives

1. Parents will share the feelings and reactions that they experienced when they learned that their children were handicapped.

2. Parents will share what was most helpful to them following the discovery of their children's handicaps.

Preparations

1. If funds permit, order and preview the filmstrip set, Working with Handicapped Children: A Special Need, A Special Love. Support from the Family (set 1). Set includes 5 full-color filmstrips, 1 LP record or 3 audiotape cassettes, 5 audioscript booklets, 1 discussion guide, and 1 library processing kit.

Price: Individual sets $99.50
Order Information:
Parents' Magazine Filmstrips
Distributed by PMF Films, Inc.
Box 1000
Elmsford, New York 10523

Sequence

1. Use one of the "Ways to Begin" to stimulate parents to share their expectations and reactions about their children before and after their births. (10-15 minutes)

2. Explore with parents their initial feelings and reactions upon learning of their children's handicaps. Ask whether they have had experiences similar to the parents presented in the filmstrip. (5-10 minutes)

3. Use questions in the section "Questions to Continue Discussion" to explore difficulties and strengths that parents in the group perceived in themselves during the period when they first learned of their children's handicaps. (10-20 minutes)

4. Discuss ways that immediate and extended family members can help in the adjustment process incorporating suggestions from the group. (5-10 minutes)

5. Conclusion and next steps. (5-10 minutes)

Ways to Begin

1. Select and show one of the Parents' Magazine filmstrips on parental reactions from the series Working with Handicapped Children: A Special Need, A Special Love. The filmstrip approaches the topic from parents' perceptions, and it is realistic, empathetic, and feeling-oriented in its treatment of the topic. This filmstrip should prompt some discussion from parents on their own reactions to the birth of their handicapped child.

2. If the filmstrip is not available, describe from personal knowledge or from material read how parents commonly react to discovering their child has a handicap.

Information to Consider

The decision to become parents is one of the most important decisions in the life of a husband and wife. The birth of a baby is the culmination of parent's plans, expectations, and hopes for the future. It is not surprising, therefore, that the birth of a baby afflicted with a handicap is a crushing blow to the parents, grandparents, and other relatives who have shared the event (Klaus & Kennell, 1982).

If one were to ask non-parents or expectant parents to describe their wishes for an unborn child, they would more than likely describe a healthy, attractive, winsome, intelligent child who will be appropriately self-sufficient. The ideal child would combine the best traits of parents and noted ancestors. Parents hope and expect to experience their child as a source of success and satisfaction (Pion & Smith, 1977), thereby meeting important ego needs and serving as a source of pride. Another important asset of parenthood lies in the comfort and assurance that one's family linkage will be continued through the generations, offering proof of one's individual existence. The dreamed-for child is often a powerful preparental and parental psychological image.

Expectant parents tend to protect themselves from thoughts about having a child with a disability by thinking, "It can't happen to me." They may have information about handicaps and mental retardation and may, to some degree, be fearful about the possibility of giving birth to a disabled infant. More often than not, this fear is dispelled by the thought that such things happen to other people, and parents hope and pray that it will not happen to them.

When a child with a handicap is born, most parents react with shock and confusion. One young father of a baby born with a cleft palate described how he walked the streets from 4 AM, when his baby was born, until late the next night, worrying about what would have to be done,

where he would get the necessary money, how he would tell his wife about the handicap, wondering about whose fault it was and a "million other things" (MacDonald, 1971). Feelings of disbelief also occur frequently. Parents may wish to be free from the situation or may deny its impact. They may find themselves repeating over and over, "This is not real. It can't be happening." Many parents recall this early period as a time of irrational behavior, characterized by frequent crying, feelings of helplessness, and occasionally an urge of flee (Klaus & Kennell, 1982). Although these general reactions are common, they are experienced in different shades and intensities by individuals and couples. Individual beliefs and values, or ideology, can have a strong influence on how one perceives, copes with, and adjusts to different life situations. What may be an inconvenience for one person may be a catastrophe for another person with similar life circumstances, but differing beliefs and values. An ideology, or belief system, can influence families as well as individuals.

As parents participate and share their feelings in the discussion group, differences and similarities in their initial reactions will become apparent. Comparing reactions reaffirms that although they are individuals, they are not alone.

Questions to Continue the Discussion

1. Ask group members whether they had had contact with any handicapped children before their own children's birth.

2. Ask group members how they felt about handicapped children before their children's births.

3. Ask parents whether they experienced any change in their feelings about children with handicaps after their children were born.

4. Ask parents how they envisioned their children would be when they were expecting.

5. Ask now the news of their babies' problems affected them when they first found out.

6. Ask parents whether they found out about their children's handicaps at birth or later, all at once, or little by little. Ask whether the timing of the discovery affected their reactions.

7. Ask whether husbands and wives were able to talk to each other about their feelings following their children's births. Ask how they were able to help each other at that time.

8. Ask who else was helpful to them after they first learned of their children's disabilities.

9. Ask parents to share ways family members and friends were helpful or not helpful (may be answered in #8). Inquire whether they could have been helpful in other ways.

Conclusion

Sumarize the initial and early reactions that parents have expressed with regard to the birth of their handicapped children. Point out that some group members had similar reactions and some had different reactions. The important thing for parents to realize is that there is no one way and certainly no right way to react or behave in such a situation. By acknowledging their feelings, parents can build upon their early and ongoing experiences to benefit and strengthen themselves and their children.

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Working with handicapped children: A Special Need a Special Love. New York: Parents' Magazine Filmstrips. (Filmstrips and LP record or audio cassettes)
Order information:
Parents' Magazine Filmstrips
Distributed by PMF Films, Inc.
Box 1000
Elmsford, New York 10523

For More Information

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(videotape)
Order information:
Intersect
1101 Seventeenth Avenue, South
Nashville, Tn. 37212

FAMILY MEMBERS HELPING AND SUPPORTING EACH OTHER: ASSISTING THE CHILD

M. Diane Smith

Physical care, health care, safety, love, security, and self-esteem are all essential for survival and well-being of both normally developing and exceptional children (Maslow, 1962). Parents are the primary caregivers for their children. However, extended family members and close friends can help in many ways to provide for the basic needs of children with handicaps.

Objectives

1. Parents and family will view, via filmstrip, some ways in which family members can be helpful to children with handicaps.

2. Parents and family members will share ways in which they have been able to lend assistance to the children with handicaps in their families.

Preparations

1. If funds permit, order and preview filmstrip, Working with Handicapped Children: A Special Need, A Special Love. Support from the Family (set 1). The filmstrip set includes 5 full-color filmstrips, 1 LP record or 3 audiotape cassettes, 5 audioscript booklets, 1 discussion guide, and 1 library processing kit. Price: Individual sets $99.50.
Order information: Parents' Magazine Filmstrips
Distributed by PMF Films, Inc.
Box 1000
Elmsford, New York 10523

2. Review the readings listed for leaders in the section "For More Information," in particular the Buscaglia and Perske readings.

3. Collect materials: newsprint pad and markers or blackboard and chalk, pencils and paper for #2 of the "Ways to Begin."

Sequence

1. Use one or both of the "Ways to Begin" as a precursor of the group discussion to follow. (20-25 minutes)

2. Use "Questions to Continue the Discussion" to discover ways that

relatives have helped or could help children with handicaps. Record suggestions. (15-20 minutes)

4. Summarize main ideas. (5 minutes)

5. Distribute handout, "Help That My Child Needs" and explain assignment. (5 minutes)

Ways to Begin

1. Show the filmstrip, "Support from the Family: Relatives" or another audiovisual item of your choosing.

2. Give participants the handout included on which to list various ways that a family member could be helpful to the handicapped child in their family or to list things that they already do.

Information to Consider

Children with handicaps have needs like those of normally developing children. These include survival and safety needs to insure life and growth; needs to feel accepted, loved and valued; and the need to learn and gradually acquire independence. Although parents are usually the primary persons responsible for providing these needs, other relatives and friends often help in these areas too.

A number of advantages exist in having relatives help children. On a practical level, the more family members who are willing and able to care for children, the more likely that their needs will continue to be met, especially when emergencies arise. In addition, having more than one person to care for children gradually broadens the base of trust that they have in significant adults in their lives.

Warm, loving feelings for children with handicaps can help increase their feelings of worth and acceptance in their family units. However, positive feelings in families may not develop completely or immediately, nor should the children be the total focus of families; Buscaglia (1975) stated:

> This will often be a slow, plodding process. Emotional strength, wisdom and flexibility come about gradually. If their guide is always the well-being of the total family, not solely that of the special child, and if they are able to see, love and enjoy the child behind the disability, they may trust that their continual growth will lead them, and the child, eventually, into acceptance.

For those families who are unable to achieve complete acceptance, they can at least over time achieve constructive adjustment.

One way that relatives and friends can help foster good feelings among all children in a family when one child has a handicap is to be sensitive about including all the children in their generosity. To

show favoritism to a child's non-handicapped siblings and to exclude the child with a handicap from fun activities, for instance, could make the child feel badly and hurt and anger parents. The same consequence can result from showing favoritism to handicapped children.

Another way that relatives and friends can help children with handicaps is by becoming familiar with their educational or therapy program If relatives babysit regularly, they can work suitable activities into the regular daily routine in a natural way. Such activities vary among children, depending upon their developmental skills.

The assistance that relatives can offer handicapped children in their families will vary, depending upon their resources and children's needs. Both family resources and child needs can change over time; however, help from relatives in some form can add a special dimension to a child's experiences.

Questions to Continue the Discussion

1. Ask group members which portion of the filmstrip reflect their own feelings and experiences.

2. Ask group members in what ways their relatives have been able to help their children.

3. Ask parents whether they have observed changes or signs of growth in their children as a result of relatives' help. Ask how these changes and growth have made them feel.

4. Ask if parents have had experiences when relatives' and friends' assistance has not been helpful. Explore ways of handling such a situation. (For example, attempt to explain in a non-threatening way the proper technique for handling the child or find a completely different way for the person to assist.)

Conclusion

Summarize ideas and suggestions participants have offered regarding ways that relatives can help their children. Recognize that while relatives and friends are an important resource for handicapped infants and children, no two sets of needs and resources will be identical. This is true for children in the same family as well as for children in different families.

Next Step

Ask parents to use the handout provided in "Ways to Begin" so that over the next week, they may make notes of ways that their child needs help and things that relatives could do or are already doing. Explain that this exercise is intended to help them think of ways that they can work together to foster children's growth and self-concepts.

References

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For More Information

For Leaders

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For Parents

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HELP THAT MY CHILD NEEDS

Over the next week, think of areas in which your special child may need assistance. Which members of your family could help in these areas?

Help that my child needs	Relatives who could help

Adapted from Abidin, 1976

FAMILY MEMBERS HELPING AND SUPPORTING EACH OTHER: ASSISTING PARENTS

M. Diane Smith

Part of the adjustment to having a handicapped child often involves becoming accustomed to changes in a family's daily routine. These changes may be stressful, especially when the care of a child requires extra time and energy. Family members can help ease these stresses.

Objectives

1. With the leader's help parents and family members will reflect on assistance parents receive from relatives, as viewed in the flimstrip shown at the previous session Support from the Family: Relatives.

2. Parents and family members will share some ideas about ways in which relatives can help parents of a handicapped child.

3. Parents will share specific ways in which relatives have helped them with their children.

Preparations

1. Have available the filmstrip Support from the Family: Relatives, which was shown in the previous session.

2. Duplicate exercise sheets for the home activity.

3. Gather materials: newsprint pad and markers or blackboard and chalk, pencil and paper for #3 of "Ways to Begin."

Sequence

1. Use one or more of the "Ways to Begin" as a precursor to the group discussion to follow. (20-30 minutes)

2. Use "Questions to Continue the Discussion" to stimulate suggestions of ways that relatives can and do help parents. Write down contributions offered. (20 minutes)

3. Summarize main ideas. (5 minutes)

4. Distribute worksheet, "Help That Parents Need." Explain assignment. (5 minutes)

Ways to Begin

1. Ask participants to share items that they listed for the "Help That My Child Needs" activity, which they did during the past week. Ask what they learned from the activity.

2. Ask for comments about the filmstrip, Support from the Family: Relatives, as it relates to relatives helping parents of handicapped children. Participants may want to see all or part of the filmstrip again. (See References.)

3. Ask participants to list some ways in which a family member could be helpful to them.

Information to Consider

Families tend to be mobilized in positive and supportive ways following an infant's birth. One or both grandmothers come for a period of days or weeks to assist with housekeeping and/or infant caregiving. Other relatives may bring food for parents and other children, may offer to help with errands and business transactions, or may keep siblings for a few days. Additional money to defray expenses incurred may be offered. Listening to parents' concerns, especially when the child is a first-born, and offering suggestions when asked also may be helpful. Therefore, assistance may include practical help, emotional support, and guidance (Caplan, 1976).

Relatives and friends can play a crucial role in the adjustments to be made by the family of a handicapped child, whether it is a newly born infant or an older child. There may be initial tension and strain around "breaking the news" to relatives about the child's special problems (Turnbull, 1976). "How will they react?" "Will they understand, sympathize and help, or blame us and cut us off?" Many other questions may come to parents' minds. If they perceive relatives' reactions to be negative, they may be unable or unwilling to talk about their child's problems or their own feelings.

Grandparents have varying abilities to cope with the stress of a handicapped grandchild. Before they can be very supportive, grandparents must accept the fact of the handicap. Their hopes for a healthy grandchild have been disappointed and, like the parents, they must readjust their expectations.

Even when relatives have supportive attitudes and intentions, they may be awkward and unsure of how to help(Turnbull, 1976). Family members and friends who live long distances from parents may be limited in the degree to which they are able to lend assistance or can get to know the children and their needs. The amount and types of help that relatives can give parents may also depend on their individual circumstances (such as work schedules and health). Families need to examine parents' needs and relatives' ability to help in different situations.

The ability to communicate needs and the willingness to help can be crucial, not only in aiding family functions but also in preventing misunderstandings. A parents may feel awkward in asking for help from a relative who hasn't offered to help. That same relative may want to help but may be unsure about the role he or she can play. According to McDonald (1962), "Many parents have reported that friends and relatives have become more understanding and accepting following a frank, objective discussion of a handicapped child's condition" (p. 40). More open communication and understanding may make it easier for parents to ask relatives for help when they need it and for relatives to offer their help when they notice the need or desire for such assistance.

Questions to Continue the Discussion

1. Ask parents what was most stressful in terms of physical energy when their handicapped child was born. Ask parents what was stressful in terms of emotional adjustment.

2. Ask parents what were some of the helpful and supportive things that relatives did at that time.

3. Ask parents what are some of the things that relatives are doing now that are helpful.

4. Ask whether parents have had difficulty asking for help.

5. Ask parents to suggest ways that relatives can help parents of handicapped children. (Ideas may include babysitting for two working parents, when parents or children are ill, or when parents need a "relaxation" break; helping with transportation; providing emotional support; providing financial aid; helping in the search for information and services).

6. Ask parents whether they have noticed changes in their relationships with relatives as a result of help that relatives have provided.

7. Re-phrase questions #6 to ask relatives who may be in attendance.

8. Ask parents whether they could offer any suggestions to relatives of handicapped children in other families.

Conclusion

Summarize ideas shared and main points discussed about relatives' assistance to parents of handicapped children: ways to help, ways to ask for or to offer help; similarities and differences in family circumstances.

Next Step

Provide parents with activity sheets to list, during the next week, ways in which they could use help and relatives who could help them. Since what is helpful to the parents may also be helpful to their child, explain that the list may overlap somewhat wih the previous week's activity list. However, this exercise is meant to provide greater awareness of ways in which relatives can help parents of handicapped children.

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HELP THAT PARENTS NEED

During the next week, record ways in which relatives may be able to help you with your child.

Help I need with my child	Who helps me	Others who could help

Adapted from Abidin, 1976.

BROTHERS AND SISTERS OF CHILDREN WITH HANDICAPS

Elizabeth Gerlock

Children who have brothers and sisters with special needs may have problems because of added responsibilities, reactions of their peers to their brother or sister, and their own feelings toward their sibling. They may also have added strengths gained from their family experience. Parents can help their children adjust by discussing their sibling's handicap with them, by including them on appropriate occasions in treatment or educational activities, and by being understanding about their negative feelings.

Objectives

1. Parents will learn about the feelings of some children who have handicapped brothers or sisters.

2. Parents will discuss the reactions of their children to their brother or sister with a handicap.

3. Parents will learn about resources such as books and pamphlets that they can use with their children.

Preparation

Write for the pamphlet There Is Something Special About You written for brothers and sisters of a child with special needs. (Available from Volunteer Information Agency, 77 Parkingway, Quincy, Massachusetts, 02169. Send a self-addressed stamped envelope.)

Sequence

1. Use one or more of the "Ways to Begin" to share information about brothers and sisters in the group. (10-15 minutes)

2. Talk about the feelings that some children have about their brothers and sisters who are handicapped. (10-15 minutes)

3. Use questions in the section "Questions to Continue the Discussion" to discover the problems and strengths of brothers and sisters in the group. (10-20 minutes)

4. Talk about ways that their children can help in their relationships with each other; include suggestions that have come from group members. (5-10 minutes)

5. Summarize the main ideas that the leader and parents have discussed and plan the next steps. (5-10 minutes)

Ways to Begin

1. Ask parents to give the names and ages of brothers and/or sisters of their handicapped child. Ask them to tell a little about their children in general and about the relationship between their handicapped and non-handicapped children.

2. Ask parents what their children feel is good about having a handicapped sister or brother and what they feel is not so good. (Parents may want to check with their children on this questions and report back to the group.)

3. Ask how parents told (or will tell) children about their brother or sister's handicapping condition. Ask how their children reacted.

4. Distribute the pamphlet There Is Something Special About You. Give group members a few minutes to read the pamphlet. Ask whether their children have any of the concerns mentioned in the pamphlet.

Information to Consider

A child with a chronic condition--mental retardation, physical disability, chronic illness, deafness, blindness, or learning disability--has an effect on all family members. The lives of mother and father, brothers and sisters, grandparents, aunts, uncles, and cousins, all are touched by a child who is handicapped. Along with parents, brothers and sisters usually have daily contact with a handicapped child, and their lives are greatly affected.

Problems for Brother and Sisters

Problems for siblings vary somewhat with the type of disability that a handicapped child has, the age of the child, the ages of the brothers and sisters, the cultural background of the family, and the sex and number of siblings (Farber, 1959; Robinson & Robinson, 1976; Gath, 1972). Young children with handicaps are often viewed primarily as babies, and many of the negative emotions described below do not occur until these children are much older. Despite some variability, experience, parent reports, and research literature indicate that many of the feelings are similar regardless of the circumstances. Some of the negative feelings reported are described below:

Annoyance. A handicapped child's increased dependence over a longer period of time often means that brothers and sisters will be called upon to babysit and to assist with child care for an extended period (Farber, 1959, 1960). If a child with handicaps is independent enough to play outside, siblings may be asked to see that she does not wander off or get into trouble. This responsibility may be a burden that curtails the freedom of the children. Brothers and sisters also find it annoying when a handicapped child does not do his share to help

around the house and takes more of their mother's and father's time (Robinson & Robinson, 1976).

Anger. Temper tantrums, stubbornness, and destructiveness of some handicapped children may anger their brothers and sisters. They wonder why he has to act the way he does. They wonder why their parents let him get away with acting in ways that they would not be allowed to act (Cerreto & Miller, 1981). They also may feel angry if their sibling interferes with what they are doing or destroys or loses some of their belongings. Some children feel anger that their family is burdened with the disabled child--they wonder why this happened to their family. They may become angry when someone treats their brother or sister unkindly.

Jealousy. Parents may have to spend more time with a child who is handicapped than with their other children, especially when there are serious medical difficulties. The physical care of a child with a disability may become very time-consuming. The other children may lack information about or understanding of their brother's or sister's condition.

Sibling rivalry can be a problem in a family with handicapped and nonhandicapped children, just as it is in other families. Brazelton (1974) cautions parents about the danger of choosing sides in conflicts among their children. His warning concerning the possible harm caused to a child by parents constantly defending a younger, weaker child seems particularly relevant in the case of children with handicaps, since many parents tend to overprotect them. Children--handicapped or nonhandicapped--who are continually protected by parents are stripped of the motivation and the need to learn to cope with siblings. They develop a sense of inadequacy in coping with others. Brazelton (1974) urges parents to let children work out their own problems. He believes that sibling rivalry can be positive but that the triangle created by child, interfering parents, and child brings about a negative experience.

Envy. Brothers or sisters of children with handicaps may feel envy when friends boast about the accomplishments of their brothers and sisters or about family activities that may not be possible for families with children with handicaps to experience (Schreiber & Freely, 1965).

Embarrassment. Teenagers may be embarrassed to have a brother or sister who looks or acts differently, who shows off or makes inappropriate remarks to their boy friends or girl friends. What may be tolerable at home--temper tantrums, stubbornness, awkward movements, strange conversation--may become embarrassing in public when people stare and comment.

Sadness. Sometimes children will feel profound sadness for a sibling who has to face life with serious problems. They may also feel sad when people stare or when other children ridicule their sister or brother.

Concern for the future. Older children may wonder if they might also give birth to a child with a special condition. They may even wonder whether they will develop similar problems. They worry about the

responsibility of caring for their sibling after their parents are gone (Cerreto, 1981).

Guilt. Children may feel guilty about the negative feelings that they have about their handicapped brother or sister. They may also wonder whether they did anything to cause his or her problems.

Benefits Resulting from Having a Handicapped Sibling

Pride. When a child who has difficulty learning finally achieves a milestone, brothers and sisters may feel a special pride. If they have helped in teaching the skill, they may feel an added sense of accomplishment.

Empathy. Becoming a more tolerant, compassionate, caring person is an especially nice benefit that can come from having a brother or sister with a handicap (Grossman, 1972). Siblings often are able to understand and relate to other people who have problems. They may choose careers in the helping professions (Cleveland & Miller, 1977).

Gratitude. Being closely associated with someone who has a handicap helps some children to appreciate their own strengths and to be grateful for them (Grossman, 1972).

Closeness with the family. Sharing a serious problem and together finding the resources to meet and adjust to it can strengthen a family and can bring a feeling of closeness and solidarity (Gath, 1972).

Love. Brothers and sisters can learn to appreciate their handicapped sibling just as he is. They may find that he is cute, says funny things, is easy to please and make happy, is very sweet, or has a rewarding smile.

How Parents Can Help

1. Discuss a child's handicapping condition as openly as possible with siblings. Studies have shown that having information about the disability, being able to ask questions freely, allowing children to visit the doctor, therapist, or special school with their handicapped brother or sister, all help strengthen the ability of siblings to cope with the problem (Cerreto, 1981; Grossman, 1972; Lavine, 1977). The problems may be complex and difficult to understand, particularly for younger children, but parents can use materials written for children such as About Handicaps (Stern, 1974) and other books included in the resource list for children in the "For More Information" section.

2. Involve siblings in playing with their handicapped brother or sister, in teaching skills, or in treatment procedures. Brazelton (1974) points out that children often strive harder to learn when taught by another child, probably out of a desire to keep up with and please the other child. However, structuring relationships should be done with great care to avoid burdening children.

3. Be open and willing to listen to problems and negative feelings. Brothers and sisters often have good reason to feel anger, resentment, and jealousy toward their handicapped sibling. Parents can best help by accepting that these are sincere, honest feelings brought about by the multiple problems that arise in living with handicapped children. After these feelings are acknowledged and accepted, family members can work together to find ways to ease tension and to meet the needs for attention and security of all the children.

4. Have a positive attitude. Parents may be struggling to find ways to live with the crisis that their child's handicaps has brought into their lives. Studies have shown that many families do find the inner resources to cope with the problem and to have a positive attitude (Grossman, 1972). The attitude of parents has been found to be the single most important factor in the adjustment of brothers and sister (Gath, 1972).

5. Help children realize that they are not the only ones who have a sibling with a handicap and that they are not the only ones to have negative feelings. Providing children with opportunities to meet other families with handicapped children can be beneficial. Occasionally groups have been organized to give young people a chance to talk about their feelings and to learn helpful ways of interacting with their brother or sister (Grossman, 1972; Kaplan & Fox, 1968; Chinitz, 1981). Perhaps parents could encourage groups such as the Association for Retarded Citizens or other parent groups to have an occasional special event or series of discussion groups to help brothers and sisters meet together. Books about handicaps are also useful, as well as informal meetings of families held at schools or day care centers where handicapped children are enrolled.

Questions to Continue the Discussion

Use some of the following questions, modifying them to fit your group.

1. Ask whether parents think that their children have any of the feelings that have been described. Ask them to give examples.

2. Explore what can be done about children's negative feelings toward a handicapped child. Suggest that parents can recognize the angry and resentful feelings that a brother or sister may have without being judgmental. Help parents learn to identify the emotion and acknowledge it ("You are feeling angry that Susie tore up your scrapbook) to give children the sense that they have been heard and understood.

3. Discuss how parents spend their time and how successful they are in finding time for everyone in the family.

4. If there are behavior problems such as temper tantrums, destructiveness, hyperactivity, or stubbornness, discuss ways that brothers and sisters can help with the problems. The Siblings Project at the University of Texas (see "For More Information") has found that behavior modification techniques--ignoring bad behavior and rewarding good behavior--can be taught effectively to siblings.

5. Ask whether children help teach, provide therapy, or assist in routine care (such as feeding or dressing) of their handicapped sister or brother. Ask for examples.

6. Ask how much time parents think that their children should spend with their handicapped brother or sister and how their children feel about their parents' expectations.

7. Ask what siblings do if their peers or other people comment about or ridicule their handicapped sister or brother.

8. Ask whether children feel comfortable about bringing friends home and how parents handle their uncertainties or misgivings.

9. Ask parents what they do when their children fight. Find out whether they handle it differently when their handicapped child is involved.

10. Ask whether children are embarrassed by their handicapped brother or sister. If yes, discuss ways that parents can help.

11. Ask how much the family has been changed by having a child with a handicap.

12. Ask family members whether having a "special child" has made them a "special family." Ask how this "specialness" has come from positive and negative changes in both individual family members and the family as a whole.

Conclusion

Summarize the strengths and weaknesses that parents have observed in their children as they relate to each other. Brothers and sisters will experience some negative feelings from time to time about their handicapped siblings and their effect on their own lives. By recognizing these feelings as valid, acceptable feelings and by having a positive attitude themselves, parents can create an atmosphere in which children begin to take pride in their handicapped sister's or brother's accomplishments, become more caring people, and become closer to their family.

Next Steps

1. Purchase or borrow some of the books about handicaps that are written for children (listed in the "For More Information" section). Lend them to group members to use at home.

2. Help parents plan a family activity that includes something to do for all the children in the family, or plan an activity in which the handicapped child and one brother or sister can participate.

3. Pick a specific concern that one or more families have; let group members suggest solutions to try during the week and ask the family to report the following week on how these solutions have worked.

4. Report answers to questions number 2 "Ways to Begin."

5. Plan a special time when children can be together to discuss their handicapped siblings, their feelings about them, and their relationships to them. Help the group begin to share by having them draw pictures of their families doing something that they all enjoy. Ask children to tell about their pictures.

Questions for discussion might include some of the following:

a. What is hard about having a brother or sister with a special problem?

b. What do you like about having a special brother or sister in the family?

c. How do you explain about your special brother or sister to your friends?

d. Does your special brother or sister embarrass you?

e. Does it help you in any way to have a handicapped brother or sister?

f. Do other children ever make fun of your brother or sister? If so, what happens? What do you do?

g. Have you taught your brother or sister anything? If so, what have you taught and why?

h. Has having a brother or sister with a handicap changed your feelings about other handicapped people?

i. In what ways has your family changed because of having a family member with a handicap?

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For More Information

For Leaders and Parents

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Siblings of children with disabilities. The Exceptional Parent, 1979, 9 (6), 29-32.

Zatlow, G. A sister's lament. The Exceptional Parent, 1982, 12(2), 50-51.

Filmstrips and Cassettes:

A special need, a special love: Children with handicaps and families who care. Set 1: Support from the family
Set 3: Brothers and sisters
Order Information:
Parents' Magazine Films, Inc.
Department F
52 Vanderbilt Avenue
New York, New York 10017

Conflicts between parents and children. (Concerns nonhandicapped children)
Set 4: Filmstrip 4--Living with brothers and sisters
Order Information:
Parents' Magazine Films, Inc.
Department F
52 Vanderbilt Avenue
New York, New York 10017

Skills for special sibs: Llving with your handicapped brotheror sister.
Videotape, children's workbook, and teacher's manual also available.)
Order Information:
Mary Cerreto, Ph.D.
Child Development
Room C143 Child Health Center
University of Texas, Medical Branch
Galveston, Texas 77550

For Children

Adams, B. Like it is: Facts and feelings about handicaps from kids who know. New York: Walker and Company, 1979. (Audience: grade 4 and up)

Brightman, A. Like me. Boston: Little, Brown & Company, 1976. (Audience: preschool; Handicap: mental retardation)

Cerreto, M. How to handle your feelings when your brother or sister is handicapped. In B. L. Phillips, (Ed.), Here's how: A directory for teenage girls. Delacarte Press, 1981.

Fassler, J. Howie helps himself. Chicago: A. Whitman, 1974. (Audience: preschool; Handicap: mental retardation)

Heide, F. Sound of sunshine, sound of rain. New York: Parents' Magazine Press, 1970. (Audience: grades 3-6; Handicap: blindness)

Sobol, H. My brother Steven is retarded. New York: Macmillan Publishing Company, 1977. (About an 11 year old girl with a retarded brother.)

Stein, S. About handicaps: An open family book for parents and children together. New Yorк: Walker & Company, 1974. (Audience: preschool: grade 3)

Wahl, J. Jamie's tiger. New York: Harcourt Brace Jovanovich, Inc., 1978. (Handicap: deafness)

SPECIAL ISSUES FOR FAMILIES WITH CHILDREN WITH SPECIAL NEEDS

CHILDREN'S VISION

Vivian Correa

Vision is extremely important in understanding and learning about the world. Better understanding of children's visual development can help parents stimulate their child's vision and detect signs of vision problems.

Objectives

1. Parents will receive basic information about eye function and signs of possible eye trouble in children.

2. Parents will be able to suggest some ideas about eye safety and first-aid for eye emergencies.

3. Parents will learn about visual development.

4. Parents will learn ways to provide stimulation to help children to use their vision.

Preparation

1. Order the following pamphlets:

"Your Eyes . . . For A Lifetime of Sight"

"Your Child's Sight . . . How You Can Help"

"Play It Safe! (For the Parent)"

"First-Aid for Eye Emergencies (Sticker)"

"Signs of Possible Eye Trouble in Children"

Available from the National Society for the Prevention of Blindness, Inc., 79 Madison Avenue, New York, New York 10016

"Insight Into Eye Sight"

Available from Bausch & Lomb, Soflens Division, Rochester, New York 14602

2. Draw a diagram of the eye on a blackboard or newsprint pad or duplicate diagram included in module.

3. nvite a vision specialist to present information about the function of the eye.

4. Duplicate handouts "First-Aid for Eye Emergencies," "Signs of Possible Eye Trouble," and "Visual Development."

5. Have blackboard and chalk or newsprint pad and marker available.

Sequence

1. Use one or more "Ways to Begin" to have parents share information about their children's vision. (5-10 minutes)

2. Provide basic information about the function of the eye. Discuss the functions of each part of the eye and compare the eye to a simple camera. (5-10 minutes)

3. Have parents participate in checking a list of "Signs of Eye Troubles." Discuss any signs which parents may have observed in their child that might indicate problems with visual functioning. (5-10 minutes)

4. Let parents read and discuss the handout, "First-Aid for Eye Emergencies" from the Society for the Prevention of Blindness. Discuss safety ideas used in their homes. (5-10 minutes)

5. Distribute the chart that describes visual development in infants. If children are below 5 months in their visual functioning, ask parents to try to approximate their children's visual development using the handout. (5-10 minutes)

6. Discuss activities to stimulate children's vision. List toys and activities that stimulate vision on the blackboard or on newsprint. (10-15 minutes)

7. Conclusions and next steps. (5 minutes)

Ways to Begin

1. Ask parents to share information about any vision problems that their children may have.

2. Ask parents to share information about their own eye problems. Ask parents how they perceive the world without corrective lenses.

3. Blindfold several parents. Ask them to identify unfamiliar objects. Discuss the skills that these "blind" parents used to name the objects.

4. Distribute a small packet that contains all the pamphlets and handouts that are listed under "Preparations."

Information to Consider

In working with children with handicaps, teachers and parents find it beneficial to assess children's development in vision along with their general abilities in the areas of gross motor, fine motor, cognition, language, social, and emotional development. Children acquire skills in these areas through their senses, especially vision, which plays a major role in development. Many case studies describe the effects of visual impairments on early childhood development (Fraiberg, 1977). Some studies have shown delays in reaching and grasping for objects and delays in creeping and walking. Fraiberg's work and other studies (White, 1963) reinforce the need to look carefully at visual development in children with handicaps.

How the Eyes Work

Each eye is like a camera or, more correctly, the camera is designed to operate like the human eye. Both the eye and the camera have an opening for light to enter, a lens or lens system, and a screen for registering an image of the visual world (Bausch & Lomb, 1975).

Rays of light reflect off of objects and enter the eye, first through a transparent substance called the cornea. After passing through the cornea, the rays of light travel through the pupil of the eye. The iris acts as a circular window shade or shutter enlarging or diminishing the size of the pupil so that the proper amount of light enters the inner chamber of the eyes (Bausch & Lomb, 1975). The rays of light then pass through a crystaline lens. Unlike a camera's glass lens, which is hard and rigid, this lens is flexible and its shape can be altered by the muscle attached to its circumference. The lens of the eye focuses the light rays on the retina. The retina is a transparent membrane attached to the back wall of the eye. It is composed of millions of tiny light-sensitive receptors. The many sensations it receives are passed along to the brain to a single complex optic nerve. The brain analyzes the messages and the person "sees" (Bausch & Lomb, 1975).

Signs of Possible Eye Trouble

Quite likely it will be difficult for parents to diagnose eye problems in their children. However, children may be giving parents some clues that their vision is abnormal. (Refer to handout) Awareness of some of the most common symptoms of eye disorders will help parents know when to seekprofessional attention to prevent possible visual damage.

Commonly Diagnosed Vision Problems

Amblyopia, or lazy eye, is often caused when one eye appears to be aligned and the other turns in or out. The brain receives two images, often called double vision (Bleck & Negel, 1975). It is thought that the child eventually will ignore the message from one eye, thus gradually weakening it through disuse. Usual treatment for amblyopia is patching the good eye in order to force the use of the weaker eye. Sometimes

this treatment is combined with glasses, surgery, or eye exercises.

A related eye problem is strabismus, a condition that occurs when the eyes are not properly aligned and instead turn in (crossed eyes) or out (wall eyes). Strabismus may be due to birth injuries, heredity, faulty muscle attachments, excessive far-sightedness, or certain illnesses. It cannot be outgrown nor will it improve by itself. Treatment directed toward straightening the eyes can involve glasses, patching, eye-drops, surgery, and eye exercises, singly or in combination. This condition should be corrected before age 5 or 6.

Refractive errors occur when light rays are not focused on the retina. Myopia, or nearsightedness, causes children to have difficulty seeing objects at a distance. Hyperopia, or farsightedness, causes difficulty in seeing objects at close range. Astigmatism causes blurred vision. These conditions can be corrected by glasses.

Eye Safety

Preventable eye injuries strike Americans at a rate of more than a half a million every year. Eye accidents are a particular threat to youngsters (National Society for the Prevention of Blindness, 1978). Improperly constructed toys present potential safety hazards. Parents should be certain that toys are safe and appropriate according to their child's age. Parents should teach youngsters safe play for safe sight.

The National Society for the Prevention of Blindness lists first-aid eye emergencies. (Refer to handout)

Visual Development

With visual development, as with cognitive or motor or social development, one stage is a prerequisite for another. In motor development, children have head control, creep, stand, and balance before they can walk. In visual development, infants need to fixate on objects before they can begin to follow or tract a moving object. The handout included describes visual development from 1 week to 5 months.

Stimulating Children's Vision

The Functional Vision Inventory (Langley, 1982) provides an easy-to-use assessment of a child's visual abilities and suggests activities for each visual skill assessed. Some of the activities are listed below:

a) use lights to get children to track,
b) dangle brightly-colored toys and objects over cribs or at eye level for children to play with,
c) present large toys 12 or 18 inches away to encourage reaching,
d) place favorite toys to the sides of children and in all directions for them to locate,
e) shift noise-making toys from left to right and up and down to get children to shift their gaze,

f) present children with small objects or food, such as raisins, dry cereal, on highly contrasting surfaces so that they can locate them and use their near vision

g) drop objects that make a sound to have children look for them,

h) hide objects under boxes or scarves to have children look and find. Children with visual problems will need to have toys that make sounds, toys with a high degree of contrast, and toys with interesting textures.

Questions to Continue Discussion

1. Have parents share ideas about different kinds of toys that they find stimulating for their children's vision.

2. Make a list of household toys or objects that can stimulate vision.

3. Make a list of activities to stimulate vision. Have each parent add activities or share activities that they have done with their children.

4. Ask parents whether they have ever seen or been to an opthalmologist who specializes in pediatricts. Discuss the choice of opthalmologists in the community. Offer names or resources where parens can find information about visual development.

Conclusion

Summarize the information that parents have received about their children's vision. Emphasize the importance of vision to other areas of development and learning. By understanding vision and visual development, parents should have a better idea of activities, materials, and resources to begin a program in visual stimulation for youngsters with handicaps.

Next Steps

1. Invite a speaker from the Society for the Prevention of Blindness.

2. Plan a more detailed discussion about the examination or assessment of infants' visual development, if interest warrants.

3. Films, cassettes, and slides on vision are available through the Society for the Prevention of Blindness, the local state Department of Education, or local library.

4. The group may want to visit the local school for the blind to learn about programs for blind children.

5. A visit to a local opthalmologist would be extremely helpful in explaining the medical aspects of eye problems and eye examinations. Parents could see the equipment used to exaamine their children's vision.

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American Printing House for the Blind. Sensory stimulation kit: A teacher's guidebook. Louisville, Kentucky, 1979.

Carolan, R. H. Sensory stimulation and the blind infant. New Outlook for the Blind. 1973, 67, 119-126.

Halliday, C. The visually impaired child. Growth, learning, development: Infancy to school age. Louisville, Kentucky: American Printing House for the Blind, 1971.

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For Parents

American Foundation for the Blind. Is your child blind? New York.

Barry, M. A. How to play with your partially sighted pre-schooler. New Outlook for the Blind, 1973, 67, 457-467.

Calovini, G. Preschool learning activities for the visually impaired child: A guide for parents. Arlington, Virginia: ERIC Document Reproduction Service.

Order information:
Code number: ED 074677
Price: $8.60 plus shipping

Illinois State Board of Education. Guide for parents of preschool visually handicapped children. Arlington, Virginia: ERIC Document Reproduction Service, 1975.

Order information:
ERIC Document Reproduction Service
P.O. Box 190
Arlington, Virginia 22210
(703)841-1212

Code number: ED 064-819
Price: $5.30 plus shipping

Illinois State Board of Education. Toys for early development of the young blind child. Arlington, Virginia: ERIC Document Reproduction Services.

Order information:
Code number: ED 065-201
Price: $2.00 plus shipping

Raynor, S., & Drouillard, R. Get a wiggle on. Mason, Michigan: Ingham Intermediate School District, 1975.

Raynor, S., & Drouillard, R. Move it. Mason, Michigan: Ingham Intermediate School District, 1978.

Order information for Get a wiggle on and Move it.
American Alliance for Health, Physical Education, Recreation, and Dance
1900 Association Drive
Reston, Virginia 22091
Price: $3.75 each

Scott, E., James, J., & Freeman, R. Can't your child see? Baltimore, Md.: University Park Press, 1977.

Sokolow, A., & Urwin, C. Playmobile for blind infants. Developmental Medicine and Child Neurology, 1976, 18, 498-502.

VISUAL DEVELOPMENT

Peabody Model Vision Project, 1977

First week

Glances at and follows with eyes a target larger than 3 inches and no larger than 18-24 inches if no closer than 6-8 inches and no farther than 24 inches.

One month

Prefers bull's eye pattern

Looks towards eyes of person holding him

Smile elicited by image of face

Coordinates eyes sidewyas

Coordinates eyes up and down

Follows object from side to center (midline)

Eyes do not converge or focus accurately on such small objects as hand

Two months

Coordinates eyes sideways, up and down, in circular patterns

Follows objects as they appear from outer corner of eye past midline

Focuses at seven inches

Experiences difficulty in keeping both eyes on a target simultaneously

Stares at objects several feet away

Fixates on only one of two objects

Blinks at the shadow of his own hand

Stares at and quiets to presentation of face

Three months

Visual convergence system (focusing) fully developed

Child can adjust the focus of his eye for objects at all distances

Follows objects from one side of the body to the other for 10 seconds

Glances from one object to another

Regards object dangled in his midline

Glances at object in hand

Searches for sound with eyes

Visually recognizes mother and other family members

Four months

Sees color

Vision approximates that of an adult

Follows well a dangling object or its sound source

Smiles at image in mirror

Five months

Follows with eyes a vanishing object

Eyes coordinate in grasping

Anticipates whole object upon seeing only part of it

Attends to scribbling

SIGNS OF POSSIBLE EYE TROUBLE

1. Excessive rubbing of the eye.
2. Shutting or covering one eye.
3. Frequent blinking, squinting, or frowing.
4. Undue sensitivity to light.
5. Inflamed or watery eyes.
6. Recurring stys.
7. Crossed eyes, or misaligned eyes.
8. Red-rimmed, encrusted, or swollen area around the eyelids.
9. Discharge from eyes.

FIRST-AID FOR EYE EMERGENCIES

Chemical Burns

Eye damage from chemical burns may be extremely serious. In all cases of eye contact with chemicals:

Do flood the eye with water immediately, continuously and gently for at least 15 minutes. Hold head under faucet or pour water into the eye using a clean container. Keep eye open as widely as possible during flooding.

Do not use an eye cup.

Do not bandage the eye.

Do call a doctor.

Do keep spray cans away from children's reach. Spray cans are increasing as sources of chemical eye injuries. The force of contact compounds the injury. They must be used carefully and kept away from children.

Specks in the Eye

Do lift upper eyelid outward and down over the lid.

Do let tears wash out speck or partical. If it does not wash out, do keep eye closed, bandage lightly, and see a doctor.

Do not rub the eye.

Blows to the Eye

Do apply cold compresses immediately for 15 minutes and again each hour as needed to reduce pain and swelling.

Do see a doctor in case of discoloration or black eye, which could mean internal damage to the eye.

Cuts or Punctures of Eye or Eyelid

Do bandage lightly and see a doctor at once.

Do not wash out eye with water.

Do not remove an object stuck in the eye.

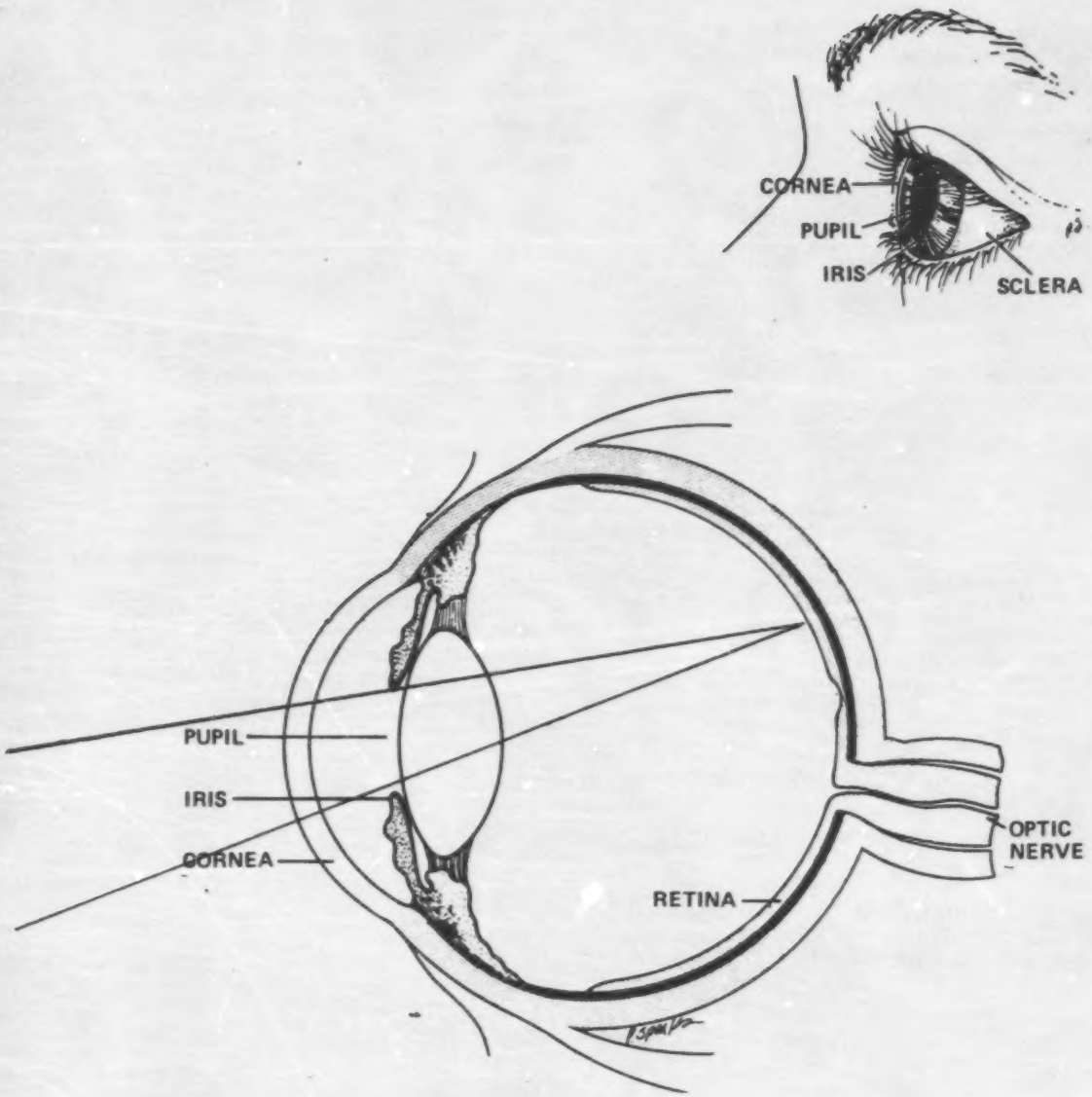

DIAGRAM OF THE EYE

(Adapted from Bleck & Negal, 1975)

CHILDREN'S HEARING

Ann Ballentine Carr

Children receive a large amount of information about the world around them through their sense of hearing. Hearing losses should be diagnosed at an early age so that children can develop in their understanding of language and in their ability to express themselves.

Objectives

1. Parents will be able to describe ear function and to name signs of possible hearing problems.

2. Parents will be able to explain three hearing tests for young children.

3. Parents will discuss medical management for hearing losses including experiences with their own children.

4. Parents will learn to talk to children who have hearing aids as well as learn stimulation activities for hearing-impaired children.

Preparation

1. (Optional) Write to request the following pamphlets:

"Helping the Child Who Cannot Hear"
Public Affairs Pamphlets
381 Park Avenue, South
New York, New York 10016

"Hearing Alert"
The Alexander Graham Bell Association for The Deaf
3417 Volta Place, N.W.
Washington, D.C. 20007

2. Draw a diagram of the ear on the blackboard or newsprint pad or make a copy of the diagram included with this module. (See "Information to Consider" section for diagram.)

3. Make copies of "Hearing Loss Symptom Checklist."

4. Gather materials: blackboard or newsprint pad, chalk or magic markers.

Sequence

1. Choose one or both of the "Ways to Begin" to introduce parents to the topic. (5 minutes)

2. Using the diagram, discuss the various parts of the ear and how they work. (Parents usually enjoy this section.) (10 minutes)

3. Distribute the "Hearing Loss Symptom Checklist" and discuss questions #1 and #2 in "Questions to Continue the Discussion." Usually parents easily share information about their child when reviewing this checklist. (10 minutes)

4. Discuss which kinds of hearing problems can be managed medically. Illustrate by referring to the diagram of the ear. (10 minutes)

5. Discuss hearing tests for young children. (5 minutes)

6. Discuss educational options for hearing-impaired children, and guidelines for communicating with children who wear hearing aids. (10 minutes)

7. Conclusions and next steps. (10 minutes)

Ways to Begin

1. Ask parents whether they have known anyone who has had a hearing problem. Ask how this person came to notice the problem.

2. Distribute the pamphlets that are listed under "Preparations." Invite parents to review the handouts and participate in any conversation that arises while they review the materials.

Information to Consider

Children receive important information about the world around them through their sense of hearing. Hearing influences children's speech and language development, as well as children's thinking processes (cognitive development). Children's hearing ability should be assessed early in order to address any problems.

Anatomy and Function of the Ear

The outer ear, the most easily seen part of the ear, acts as a funnel and directs sound into the ear canal. Hearing is approximately the same with the outer ear missing as with the outer ear present (Zemlin, 1968). Although the outer ear is the part most easily seen, it does the least amount of actual work in hearing.

The outer ear is connected to the ear canal. Ear wax, or cerumen, coats the ear canal and prevents it from drying out (Zemlin, 1968).

sound travels through the ear canal to the ear drum, or typanic membrane.

The ear drum is a thin membrane at the end of the ear canal. It vibrates like a drum when it is struck by a sound wave. The movement of the ear drum causes three bones (the hammer, anvil, and the stirrup) to move. These three bones are located in the middle ear which is about the size of a pea (Cliff, Gray, & Numan, 1974).

The sound wave next travels to the cochlea or inner ear. In the cochlea the sound wave impulses are picked up by a nerve and carried to the brain where the information is interpreted.

The Eustachian tube is a canal that is attached to the middle ear cavity and to the back of the throat. It opens with a yawn or swallow. Children's eustachan tubes are horizontal when they are small and gradually move into a vertical angle as they grow older.

Checklist for Symptoms of Hearing Loss

Distribute copies of and give parents time to read and discuss the checklist.

Hearing Losses and What Can Be Done

If children's hearing losses are in the outer or middle ear, they have a conductive loss. If the problem lies in the inner ear or in the pathways to the brain, they have a sensorineural hearing loss.

A sample of some common ear problems and treatment methods follows:

Conductive Hearing Problems

Extra wax packed in the ear canal	Doctor can flush out ear wax
Small objects, such as peas, in the ear canal	Doctors can surgically remove the objects
Ear infection in the middle ear (fluid in ear)	Doctors can prescribe antibiotics, or they may surgically put tubes in the ear drum.

Sensorineural Hearing Problems

Inner ear does not pick up sound wave messages from the middle ear.	Hearing aids can usually help. Educational intervention is needed.
Nerve is not carrying sound wave impulses to the brain.	Hearing aids can usually help. Educational intervention is needed.

Hearing Test

Audiologists can test children's hearing and determine their levels of hearing. If necessary, audiologists can use several testing situations in order to assess children's hearing. Children who are developmentally functioning on about the three-year level can be taught to do an action (for example, put a block in a box) when they hear a sound. Audiologists put earphones on children's ears and teach them to drop a block in the box each time they hear the sound.

Very young children or handicapped children may not be able to drop a block in a box each time they hear a sound. Another testing situation is then employed. In this situation, a parent and child sit in a soundproof room. The audiologist then presents sounds through speakers that are located in two opposite corners of the room and observes to see if the child will respond to a sound. When the child responds, a toy near the speakers lights up as a reinforcement.

Audiologists can also tell the status of the middle ear by conducting a test called impedance testing. With this test an audiologist inserts a probe tip into a child's ear. . .this procedure does not hurt the child, but he/she may feel slightly uncomfortable. The audiologist can gather the information without the need for the child to respond (except to remain still). Sometimes the procedure is done while children are asleep, or children are sedated. With this test, audiologist can tell whether the ear drum is as flexible as it should be and whether scar tissue or ear infections are interfering with hearing. Audiologists work closely with physicians if medical management is needed.

Educational Intervention

Once children have been diagnosed as having hearing losses, they need instruction to develop a communication system and to use the hearing that they have. In order to determine the best communication system for hearing-impaired children, their abilities and problems should be assessed individually. Consideration should also be given to family situations and the educational systems that children are in or will be entering.

Three basic methodologies are used to teach hearing-impaired children:

1. In the oral method children are taught to use residual hearing with the help of hearing aids, to develop their skills in understanding and talking, using oral language.

2. In the manual method children are taught to communicate by using a gesture system or a sign language.

3. In the total communication method children are taught to understand and talk using both oral language and sign language simultaneously.

Talking to Children Who Are Using Hearing Aids

Several guidelines for talking to children who wear hearing aids follow:

1. Since children pick up sounds and voices through their hearing aid microphones, speak directly into the microphone at a distance of about 6 to 12 inches (Magner, 1962).

2. Shouting distorts sounds and does not help children hear the sounds better.

3. Look at children when you speak so that they can see your lips as well as the expressions on your face.

4. Articulate your words clearly, but do not exaggerate your mouth movements. Exaggerated movements are confusing.

5. Other suggestions are outlined in the module "The Rules of Talking."

Intervention Activities

Children who have significant hearing losses need to be taught to listen, which is a very difficult task for them. Activities need initially to concentrate on teaching children to attend to and be aware of environmental sounds and voices. An example from the Mama Lere Home Auditory Training Program is the "Knocking Game"; children listen for knocking at the door, then answer the door when they hear the sound. In the activity "Sounds of Home Objects," parents point out the source of sounds of household objects such as the sound of the vacuum cleaner running, the water faucet being turned on and off, and a clock ticking. Parents then vocalize a sound that the household objects makes--for example, "shh" for running water.

After children attend to sounds and voices, localization skills need to be taught. In the "Calling Game," adults call children's names while sitting behind the children. Other adults cue the children to turn when their name is called.

Next, auditory discrimination skills are taught in order to help children differentiate sounds as well as words. In the "Sound Box Activity," children identify toys located in a sound box by an identifying sound or word, such as "moo" for a cow or the name of the toy.

Children also are encouraged to vocalize throughout the day. They should be encouraged to imitate parents talking; see the module "Rules of Talking" for specific suggestions.

Questions to Continue the Discussion

1. Ask parents whether their children have exhibited any of the symptoms listed on the "Hearing Loss Symptom Checklist."

2. Ask parents who respond to number 1 if their doctor found a problem with their child's hearing when these symptoms were present.

3. If there is a parent in the group who has a hearing-impaired child, the leader might ask the following question: "Both children and parents need to make adjustments when a young child needs to wear a hearing aid. How has this adjustment been for you and your child?"

4. Ask parents whether any of their children have had tubes surgically placed in their ears. If the answer is yes, ask how it has affected their children's hearing.

5. Ask parents whether any of them had to wear a hearing aid or had tubes placed in their ears. Ask them to describe their experiences.

6. Ask parents to share activities or games that they have used with their children to develop their listening or talking ability. Make a list of these activities on the blackboard.

7. If parents have had their children's hearing tested, ask them to share their experiences.

Conclusion

Summarize the information that parents have received about their children's hearing. In the summary, include information and experiences that the parents shared during the session. A summary might include the following:

The ear is a delicate instrument that transmits important information about the world to us. When the ear has problems transmitting information, an evaluation needs to be conducted to determine where the problem lies. Children who have conductive hearing losses usually can have their problems resolved by a doctor through medical management. Children with sensorineural hearing losses usually can benefit from a hearing aid and educational intervention.

Next Steps

1. Arrange for parents of hearing-impaired children to visit local schools that serve hearing-impaired children.

2. Include in the parent library books and pamphlets that discuss hearing problems and what can be done about them.

3. The modules "Speech and Language Development" and "Rules of Talking" are recommended to preceed or follow this module.

4. Arrange a training session on "Caring for your child's hearing aid" for parents whose children have hearing-impairments. A helpful reference to guide this demonstration/discussion is "Ears to Hear."

5. Parents are sometimes interested in talking with parents who have an older child who has hearing-impairments. Arrange a time for parents to visit the group and discuss their experiences. Ask them to discuss their feelings when they found out their child was hearing-impaired, their child's educational experience in school, and their family's reactions to having a hearing-impaired child.

References

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Hanners, B., & Sitten, A. Ears to hear: A daily hearing aid monitor program. Volta Review, 1974, 76(9), 530-536. (Reprints available for $.25 from Intersect, 1101 17th Avenue, South, Nashville, Tn. 37212.)

Horton, K. Mama Lere Home Auditory Training Program. Unpublished manuscript, 1970. (Available from Mama Lere Home, Bill Wilkerson Hearing and Speech Center, Vanderbilt University, Nashville, Tn. 37212.)

Magner, M. A short course in auditory training. Paper presented at the National Meeting of the Alexander Graham Bell Association, Detroit, 1962.

Zemlin, W. Speech and hearing science: Anatomy and physiology. Englewood Cliff, N.J.: Prentice-Hall, Inc., 1968.

For More Information

For Leaders

Elwood, P., Johnson, W., & Mandell, J. Parent-centered programs for young hearing-impaired children. Upper Marlboro: Prince George's County Public Schools, 1977.

Kody, J. (Ed.). Handbook of clinical audiology. Baltimore: Williams & Wilkins Company, 1972.

Northcott, W. H. (Ed.). Curriculum guide: Hearing-impaired children (0-3 years) and their parents. Washington: The Alexander Graham Bell Association for the Deaf, Inc., 1978.

Northern, J. L., & Downs, M. P. Hearing in children. Baltimore: Williams & Wilkins Company, 1974.

For Parents

Bloom, F. Our deaf children. London, England: Redwood Press, 1963.

Pushaw, D. Teach your child to talk. Fairchild, M.J.: Cebco Standard Publishing, 1976.

Thielman, V. B. John Tracy Clinic Correspondence Course for parents of preschool deaf children. Los Angeles: John Tracy Clinic, 1968.

CHCEKLIST FOR SYMPTOMS OF HEARING LOSS

If a child has one or more of these symptoms, he/she may have hearing difficulty and hearing should be checked.

If a child has a bad odor or smell coming from the ear.

If a child has repeated bouts of upper respiratory infections, running nose, chronic cough, or ear infections.

If a child pulls, rubs, or digs in her/her ears.

If a child has poor or delayed language development.

If a child has poor articulation of speech sounds.

If a child depends on visual clues to complete simple verbal tasks.

If a child has a short attention span.

If a child is easily distracted or frustrated in a group.

If a child does not respond consistently to his/her name or to voices.

If a child has difficulty finding the source of a sound.

If a child needs to have verbal instructions repeated several times before understanding them.

If a child does not particularly like television, records, radio, or word/rhyme games.

If a child has poor sentence structure and speech.

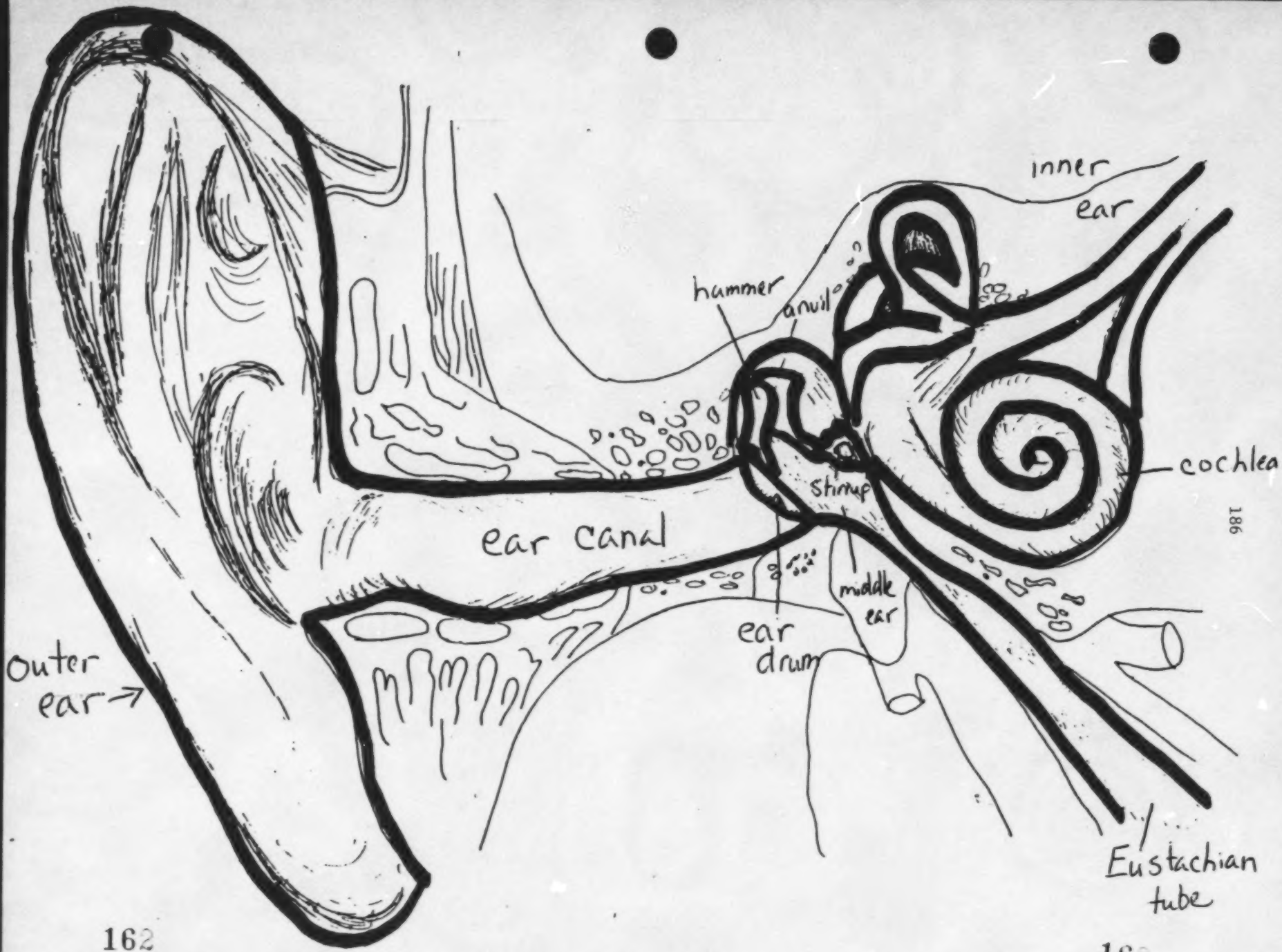
If a child is very inattentive during story time.

If a child cannot understand you when not facing you.

If a child watches your face and eyes for visual clues of meaning.

If a child talks in an extremely loud or soft voice.

In J. Coscarelli, C. Chrisman, & S. Ward. A child talks. . .What we can do to help. Nashville Urban Observatory, Title XX Day Care Teacher Training Grant, 1977.


inner ear
hammer
anvil
cochlea
stirrup
ear canal
middle ear
ear drum
outer ear
Eustachian tube

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IT'S THE LAW - EDUCATIONAL RIGHT FOR CHILDREN WITH HANDICAPS

Phyllis Sells

Public Law 94-142, passed by the United States Congress in 1975, guarantees that all handicapped children will be provided a free, appropriate public school education. Knowledge of this law, an understanding of the local school administration, and a degree of assertiveness are tools that will enable parents to be advocates for their children as they participate as responsible members of the team that plans the appropriate educational program for their children. (A special note: at the time of writing this section, the Reagan Administration has issued new regulations to replace existing ones for PL 94-142; it remains to be seen, whether these new regulations will be approved.)

Objectives

1. Parents will be familiar with Public Law 94-142 which outlines their rights and the rights of their children.

2. Parents will improve their understanding of the workings of their local school system as it relates to special education and will be provided with the names of persons responsible for special education programs.

3. Parents will develop their skills for assuming the role of advocate for their child.

Preparation

1. Duplicate copies of a summary of Public Law 94-142 for each parent. (For a good summary, see Thomas Powell's article listed in "References.")

2. Order the following pamphlets:

   It's the Law
   These Are Not Reasons
   Least Restrictive Environment
   Education, The Right of Every Child

These pamphlets are available free from the Tennessee State Department of Education, Right to Education Office, Room 104, Cordell Hull Building, Nashville, Tennessee 37219. Other states may provide similar pamphlets.

3. Ask the local school system for a copy of the IEP (Individualized Educational Plan) form that is used for writing objectives for handicapped children and provide parents with a copy of this form.

4. Find out the names of persons responsible for special education services and programs in the local school system.

5. Gather materials: paper, pencil, and folder for each parent, a summary of the law, a copy of the IEP from the local school system, and a list of materials for parents to read.

Sequence

1. Using "Ways to Begin," talk about the education of handicapped children past and present, and how Public Law 94-142 materialized. (5 minutes)

2. Review the summary of the law and its main points. (20 minutes)

3. Have parents fill in a sample IEP form and discuss their role in decisions that affect their children. (15 minutes)

4. Review parents' rights and their need to exercise them: for example, their right to observe their child's class or to call a conference at any time. (5-7 minutes)

5. Using "Questions to Continue the Discussion," explore advocacy techniques. (5 minutes)

6. Conclusion and Next Steps. (5-7 minutes)

Ways to Begin

1. Ask parents whether they remember having any handicapped classmates when they were children, if so, ask them to share their experience with the group.

2. Distribute a summary of Public Law 94-142 and any phamplets about the rights of children with handicaps that are available.

Information to Consider

Probably not too many people in the group had handicapped children in their classes when they were in school because, although public education is the birthright of every American child, this right was routinely denied to millions of the nation's handicapped children. However, in 1975, a law was passed by Congress in an effort to change this pattern of neglect. This law has had a tremendous effect on handicapped children and their parents.

Public Law 94-142

The rights outlined in Public Law 94-142 need to be reviewed and discussed to make certain that parents understand the intent of the law and how to use it to enhance their child's education. These rights are:

1. A free, appropriate public education. As of September 1, 1978, all handicapped children ages 3 to 18 years are entitled to educational services. The services must meet each student's needs and must be provided without a bureaucratic delay. Related services are also mandated by the law if a child needs them. These services might include, for example, physical therapy, transportation, or speech therapy.

2. An Individualized Education Plan. The law requires that each child who receives special education have an Individualized Education Plan (IEP). The IEP is the basis for the child's entire learning program. It has two main purposes:

a. To establish learning goals for the child.
b. To establish services that the school district is required to provide to help the child meet these learning goals.

The IEP is formulated at a planning meeting by the multidisciplinary team (referred to as the M-Team). This team includes the parent, child (if appropriate), teacher, principal, and any other persons requested by the parents or the school. The services stated in the IEP must be provided by the school district at no cost. IEP meetings must be held at least once a year, and parents are to receive a copy of the IEP.

3. Opportunity to participate in critical educational decisions. Parents have the right to participate in decisions regarding their child's evaluation, diagnosis, placement and program changes. The law states that parents must be notified and their permission must be rendered before children are tested or transferred to a different class (or their program changed.)

4. Access to all school programs and facilities. Handicapped children have the right to participate in all school programs such as assemblies, school plays, or athletic events, to the maximum extent appropriate to meet their needs.

5. Instruction in the "least restrictive environment." This very important term simply means that handicapped children must be educated in a manner similar to their nonhandicapped peers unless it can be proved that the alternative to that education or treatment is more beneficial to the child than placement in a regular classroom. In most cases, educating handicapped and nonhandicapped children together is beneficial to both groups. (For justification of educating handicapped and nonhandicapped children together read: The Silent Minority.)

6. Due process procedures to handle parent-school disputes. There may be disagreements between parents and school personnel about what is best for the child. Most of these conflicts can usually be settled by

talking with the teacher or principal. However, if disagreements persist about the placement, or services offered or not offered, encourage parents to avail themselves of their right to a due process hearing. The purpose of such a hearing is to resolve disagreements in a fair and impartial manner. Most states have resources to assist parents in a due process hearing. In Tennessee two such resources are:

a. Project EACH (Education Advocacy for Children with Handicaps)
Box 24321
Nashville, Tennessee 37202
1-800-342-1660

b. Right to Education Office
Room 104, Cordell Hull Building
Nashville, Tennessee 37219
615-741-2963

7. Examination of child's school records. Parents have the right to review their child's school file at any time. They can also request that certain materials be amended if it is inaccurate or misleading or if it violates the privacy or other rights of their child. If the school decides not to amend the child's records, parents may request a due process hearing. If, as a result of the hearing, the records are not amended, parents have a right to place in the records a statement commenting on the information or setting forth any reasons for disagreeing with the decision of the agency.

8. Evaluation. Children have a right to a full individual evaluation before any action is taken regarding placement. The evaluation must not be racially or culturally discriminatory and must be in the child's native language. If the child has impaired speaking skills or impaired sensory or manual skills, the test must be administered so as to reflect adequately the aptitude or achievement being tested rather than the child's impairment. No single procedure is adequate for determining a child's educational program. Specific areas must be assessed rather than using one test that provides a single general intelligence quotient. The evaluation must be done by a trained multidisciplinary team, and the child must be assessed in all areas related to the suspected disability.

Questions to Continue the Discussion

1. Discuss with parents the importance of their participating in formulating their children's Individualized Education Plans. Provide them with sample IEP forms and ask them to fill them out for their children. Usually there are blanks for educational goals as well as for related services. Have parents fill in what they feel their children need to accomplish academically during the year, as well as listing services that their children will need such as transportation, special toileting assistance, or speech therapy. Make certain that they understand this procedure and that they know what their children will need. This activity will help prepare them for their participation in the M-Team process.

2. Ask parents what it means to be an advocate for their children (to stand up for, to speak on their behalf).

3. Ask what kind of activities will help them be an effective advocate. For example: visit their children's classes; call a conference if there is a problem; realize that they know their children better than anyone else and that they have more concern for their chidren than anyone else; keep a file on all reports, and correspondence.

4. Ask parents to share ideas about how to deal with school officials. Suggestions might include:

a. Be firm in your dealings but do not be offensive.
b. Read materials on the art of negotiation.
c. Talk with other parents and stay in touch with parent groups.
d. Take another parent with you when discussing a problem with school personnel.

Conclusion

Public Law 94-142 is an extensive document of great important to all handicapped children and their families. Encourage parents to know it well and to become an "expert."

Next Steps

Encourage individual parents or arrange for the entire group to visit the school(s) and observe classes and programs that might be available to their children. Several parents might want to go together. This would be a good time to give them the names of persons directing special educational programs in the local school system and for them to meet some of these people and teachers in the schools.

References

Gliedman, J., & Roth, W. The unexpected minority: Handicapped children in America. Harcourt, New York: Brace & Jovanovich, 1980.

Powell, T. Educating all disabled children: A practical guide to 94-142. Exceptional Parents, 1978, 8(4), 13-16.

For More Information

For Parents

Copeland, J. Your handicapped child's education. Tennessee Association for Retarded Citizens, 1700 Hayes Street, Suite 201, Nashville, Tennessee 37203. (Free)

Mopsik, S., & Agard, J. An education handbook for parents of handicapped children. Cambridge, Mass.: Abt Books, 1980.

Yohalem, D., & Dinsmore, J. 94-142 & 504: Numbers that add up to educational rights for handicapped children. Children's Defense Fund, 1520 New Hampshire Avenue N.W., Washington, D.C. 20036. (Free)

COMMUNITY RESOURCES AND SERVICES: SOCIAL, MEDICAL, AND ADVOCACY RESOURCES

M. Diane Smith

(Note to leader: This session may be conducted as a panel discussion, as outlined, or as separate sessions for each speaker. Ask parents well in advance for suggestions about professionals and agency representatives whom they would like to invite as guest speakers/panelists.)

Handicapped children may need special kinds of help from a variety of professionals and agencies. Parents can obtain help for their children more easily when they know where to go for service, which services an agency offers, how to apply for services, and what the eligibility guidelines for services are.

Objectives

1. Parents will become acquainted with some of the social, health, and advocacy services available in their community to serve their children and families.

2. Parents will become familiar with the procedures for applying for services.

Preparation

1. Well in advance of the session, contact a pediatrician or other health professional, a social worker, and an attorney or a representative from an advocacy group to request their participation on the panel.

2. Ask speakers to bring pamphlets from their agencies; or write to several agencies included on the list "National Agencies and Resources."

3. Duplicate list of "National Agencies and Resources" to distribute.

Sequence

1. Explain the purpose of the session. (5 minutes)

2. Introduce the guest panelists. (5-10 minutes)

3. Have panelist present information on the following:

a. Social Services (10-20 minutes)

b. Medical/Health Services (10-20 minutes)

c. Legal and Advocacy Services (10-20 minutes)

Time alloted will be determined by the number of speakers.

4. Provide a questions and answer period. (15-20 minutes)

5. Conclude by thanking the speaker(s).

6. Serve refreshments.

Ways to Begin

See Sequence #1 and 2.

Information to Consider

Panelists will determine the content of their presentations; however the leader may provide the following suggestions about areas to discuss:

Social Services

The speaker should define generally what a social service is, who it usually serves and what it does. An overview of some specific child and family services in the geographic area can give participants an idea of what these agencies do and whether they have resources that parents might want to investigate and use. Application processes for these services and persons to contact at these agencies might also be provided in a handout.

Medical/Health Services

The speaker should give an overview of medical clinics and services available in the participants' area, including locations and types of medical help that they provide. Clinics and services might include such agencies as State Crippled Children's Services; clinics that provide physical therapy speech and hearing evaluations and therapy; and other similar services of interest for children and their families. Information on application procedures should be provided.

Advocacy Services and Organizations

The speaker should review the rights of parents and their children in terms of access to systems, services, and information about and for their children with special needs. The discussion should include what is meant by legal services and advocacy and should include information on where to go for help (location and names of services). The application process and names of persons to contact should also be provided.

In like manner, participants should be made familiar with special advocacy groups that parents may use and/or join--for example, Association for Retarded Citizens (ARC), Spina Bifida Association, United Cerebral Palsy--and the roles that they play.

Question and Answer Period

Time should be set aside for participants to ask questions of speakers. (A longer question and answer period can be held if each topic is presented as a separate session.)

Conclusion

If they have not already done so, allow a few minutes for panelists to distribute any pamphlets or handouts that they may have brought. Thank them for their participations.

Refreshments

This period will allow participants and guest panelists to become acquainted, and some parents may want to ask questions of individual speakers in this informal setting.

For More Information

For Parents and Leaders

(Locate local and state directories of services available for your area.)

Barnes, B. The educational rights of your handicapped child. Richardson, Texas: 528 Shirley Court, undated, 50¢.*

*Price information may have changed.

ERIC Order Information: ERIC Document Reproduction Service
P.O. Box 191
Arlington, VA 22210

Direct information for parents of handicapped children: Agencies, child advocacy groups, sources of financial aid. King of Prussia: National Learning Resource Center of Pennsylvania, 1977. (ERIC #149505, 48pp., *unit price $2.06)

Directory for exceptional children: A list of educational and training facilities, 9th edition, 1981-82. Boston: Porter Sargent Publishers, Inc., 1981. (11 Beacon St., Boston, Mass. 02108)

Directory of national information sources on handicapping conditions and related services. Washington: U.S. Department of Health, Education, and Welfare, 1980.

Nechen, D. Health education literature for parents of physically handicapped children. American Journal of Diseases of Children, 1977, 131, 311-315.

NATIONAL AGENCIES AND RESOURCES FOR EXCEPTIONAL CHILDREN

Alexander Graham Bell Association for the Deaf
3417 Volta Place, N.W.
Washington, DC 20007
202-337-5220

American Foundation for the Blind, Inc. (AFB)
15 W. 16th Street
New York, NY 10011
212-620-2000

American Physical Therapy Association (APTA)
1156 15th Street, N.W.
Washington, DC 20006
202-466-2070

American Speech-Language-Hearing Association (ASHA)
10801 Rockville Pike
Rockville, Md 20852
301-897-5700

Association for Education of the Visually Handicapped (AEVH)
919 Walnut Street, 4th Floor
Philadelphia, Pa 19107
215-923-7555

Association for Retarded Citizens (ARC)
National Headquarters
2501 Avenue J
Arlington, Tx 76011
817-640-0204

Association for the Severely Handicapped (TASH)
1600 West Armory Way
Seattle, Wa 98119
206-283-5055

Birth Defects Foundation
1275 Mamaroneck Avenue
White Plains, NY 10605
914-428-7100

Closer Look
Parents' Campaign for Handicapped Children and Youth
Box 1492
Washington, D.C. 20013
202-883-4160

Down's Syndrome Congress
Penny Schimpler, Corresponding Secretary
706 S. Bunn Street
Bloomington, Ill. 61701
Home: 309-829-8509
Work: 309-827-6107

Epilepsy Foundation of America (EFA)
4351 Garden City Drive
Landover, Md. 20785
301-459-3700

National Association for the Deaf-Blind
2703 Forest Oak Circle
Norman, Okla. 73701
405-360-2580

National Association of the Dean (NAD)
814 Thayer Avenue
Silver Spring, Md. 20910
301-587-1788

National Association for Visually Handicapped
305 East 24th Street, 17-C
New York, NY
212-889-3141

National Center for Law and the Handicapped, Inc. (NCLH)
P.O. Box 477
University of Notre Dame
Notre Dame, In 46556
219-283-4536

National Easter Seal Society
2023 West Ogden Avenue
Chicago, Ill. 60612
312-243-8400

National Library Services for the Blind and Physically Handicapped
Library of Congress
1291 Taylor Street, N.W.
Washington, DC 20542
202-287-5100

National Society for Autistic Children (NSAC)
1234 Massachusetts Avenue, N.W.
Suite 1017
Washington, DC 20005
202-783-0125

Spina Bifida Association of America
343 South Dearborn Street
Suite 319
Chicago, Ill. 60604
312-663-1562

The Council for Exceptional Children
1920 Association Drive
Reston, Va. 22091
800-336-3728 (except Virginia)
703-620-3660 (Virginia, collect calls are accepted)

United Cerebral Palsy Associations, Inc. (UCPA)
66 E. 34th Street
New York, NY 10016
212-481-6300

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